The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices:
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Contents

March, 1959, Volume 36, No. 3

Cover picture—View of an interior court at W.C.B.'s Hospital and Rehabilitation Centre (see page 39)

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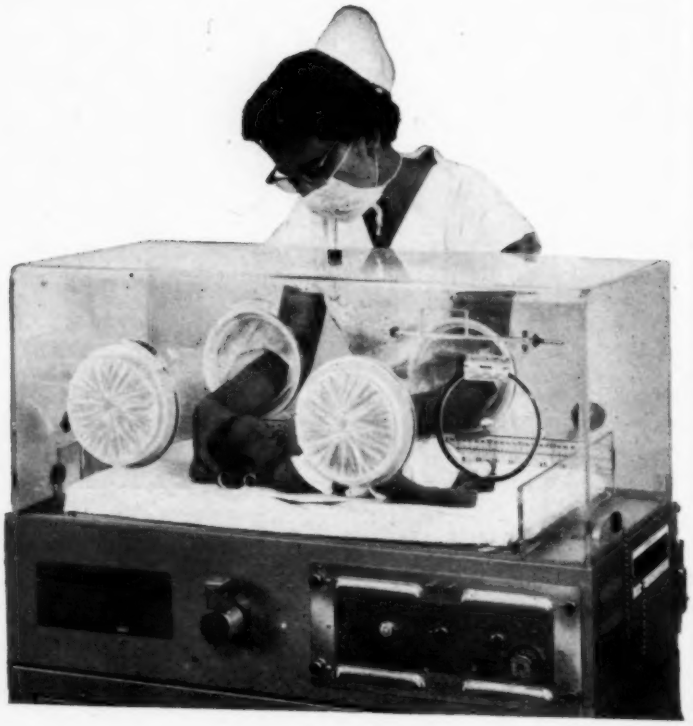

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*Zinsser, H.: Bacteriology, ed. 11, New York, D. Appleton-Century Company, Inc. 1957, p. 244.

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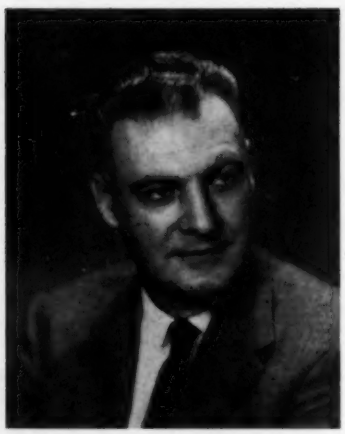
Notes About People

Chief Executive Officer Associated Hospitals of Alberta

Murray W. Ross who, for the past nine and a half years, has been assistant director of the Canadian Hospital Association has accepted the newly created post of chief executive officer for the Associated Hospitals of Alberta. Although the board of directors and the staff at the national office will miss his dynamic personality and enthusiasm, we are glad that his experience in organization and management will benefit a provincial association. The hospitals of Alberta are to be congratulated upon their choice of an executive officer.



Murray W. Ross

Prior to joining the staff of the Canadian Hospital Association in 1950, Mr. Ross had been successively executive-secretary of the Lamont Public Hospital in Lamont, Alta., and secretary-treasurer of the Royal Alexandra Hospital in Edmonton. He is a past president of the Associated Hospitals of Alberta and a former trustee and member of the executive of the Alberta Blue Cross Plan. He has for many years been a member of the American College of Hospital Administrators and when he came to the national office was already chairman of the association's Committee on Accounting and Statistics.

Through the years he has been constantly associated with the work of that committee: and during the many months of work required to produce the *Canadian Hospital Accounting Manual* he was a major contributor and co-ordinator of activities. He was also embroiled in the revision of that volume which is now used by the majority of the hospitals of Canada.

The past nine years have been a period of development and expanded activity for the association and Mr. Ross has taken part in almost every phase, including the establishment of two extension courses—one in hospital organization and management and the other for the training of medical record librarians. He has been associate editor of the *Canadian Hospital Directory* and has been instrumental in increasing substantially the circulation of *Canadian Hospital*. Each year he has attended conventions and other hospital meetings across Canada and is well-known as an excellent speaker and a vigorous proponent of good accounting methods. When he goes to assume his new post in July, his many friends will join us in wishing Murray Ross every success and happiness in the province of Alberta where he will receive a welcome home.

N.B. Section Now Has Executive Secretary

Charles Gerald Bird has been appointed executive secretary to the New Brunswick Section of the Maritime Hospital Association. Mr. Bird attended St Joseph's College in St. Joseph, N.B., and Sir George Williams College in Montreal, Que.; and has had several years of experience in banking, accounting and business administration. His duties will now include, along with normal secretarial functions for the Section, the study of trends and developments in the hospital field, interpretation of hospital problems, the collection, dissemination and exchange of information among member hospitals, and liaison work between the members and organizations such as the Workmen's Compensation Board, Blue Cross and local government bodies. His office address is Box 158, 67 St. Francis Street, Edmunston, N.B.

Charles G. Bird

With Department of National Health and Welfare

Dr. E. W. R. Best, until recently director of British Columbia's Central Vancouver Island Health unit, Nanaimo, B.C., has been made chief of the Epidemiology Division in the Department of National Health and Welfare, Ottawa.

Dr. Best, born in China, the son of Dr. A. E. Best, professor of internal medicine at West China Union University, took his medical degree at the University of Toronto in 1944. After service with the armed forces he returned to the university to receive his Diploma in Public Health in 1947. Before his post in Nanaimo, he was director of North Okanagan Health Unit in Vernon, B.C.

Business Manager at Holy Cross

Business manager at Holy Cross Hospital, Calgary, Alta., is Robert G. Aman, who succeeds Victor Pryce in this post. Mr. Pryce is now with the Alberta Crippled Children's Hospital. Mr. Aman, a native of Belleville, Ont., is a chartered accountant, and was comptroller and business manager of the Winnipeg General Hospital, Winnipeg, Man., before his new appointment.

Surgeon-in-Chief Appointed

Dr. H. Rocke Robertson of Vancouver has been appointed surgeon-in-chief of the Montreal General Hospital, Montreal, Que., and chairman of the department of surgery at McGill University, effective July 1.

(continued on page 16)

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People

(continued from page 10)

Dr. Robertson is at present professor of surgery at the University of British Columbia and chief of surgical services at the Vancouver General Hospital and Shaughnessy Military Hospital in Vancouver, B.C. A graduate of McGill, he studied in Edinburgh and served during the second world war as commanding officer of No. 1 Field Surgical Unit, Royal Canadian Army Medical Corps.

Quebec Minister of Health

Dr. Albini Paquette, Minister of Health in Quebec since 1936, has been appointed to the Quebec Legislative Council. Quebec's new Minister is Dr. Arthur Leclerc, a practising surgeon of Murray Bay, who was a minister without portfolio in the provincial cabinet at the time of his appointment to the health department.

Leaves Ross Memorial

Norman Mutter, after four years as administrator at the Ross Memorial Hospital, Lindsay, Ont., has left that post to go to Peterborough, Ont., where he has purchased the Credit Bureau of Peterborough Ltd. Mr. Mutter was formerly administrator of the Archer Memorial Hospital in Lamont, Alta., for two and a half years, and was for six years credit manager of the Kingston General Hospital.

Now at Chapleau

George J. Riesz, a graduate of the University of Toronto's course in hospital administration, and the first winner of the Robert Wood Johnson Award, is now administrator of the Lady Minto Hospital, Chapleau, Ontario. Mr. Riesz has been with the New Mount Sinai Hospital, Toronto, Ont., for the past few years, serving as administrator of the out-patient department and as administrative assistant.

New Director at Jewish Hospital of Hope

Newly appointed as executive director of the Jewish Hospital of Hope in Montreal, Que., is Manuel Cohen. Mr. Cohen was formerly assistant director of Montefiore Hospital in New York, N.Y., and is a member of the American College of Hospital Administrators. He has also been a member of the board of directors of the Mosholu Community Centre of the Associated Y.M.H.A. in New York and on the board of advisors of Retarded Infants' Services, Incorporated. He is a graduate of Boston University, and has had graduate training in public health and hospital administration at Yale University.

At Montreal Children's

George H. Shaw, a 1953 graduate of the C.H.A.'s course in hospital organization and management, is now assistant director at the Montreal Children's Hospital, Montreal, Que. Mr. Shaw was assistant administrator of the Royal Edward Laurentian Hospital, Montreal, until 1952 when he went to the Royal Victoria Hospital there where he was for six years on the administrative staff.

R.C.A.F. Changes

Flight Lieutenant Ted Gerein, a 1956 graduate of the C.H.A.'s extension course in hospital or-

(concluded on page 26)

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p.17-24 ads.

ganization and management, has been promoted to Squadron Leader. Formerly on the staff of R.C.A.F. Hospital, Rockcliffe, Ottawa, Ont., he is now at 3 Fighter Wing Hospital in Zweibrucken, Germany.

A 1958 graduate of the extension course is Flying Officer Joe Tunney who has been made Flight Lieutenant and is on the staff of the Director General Medical Services for Air in Ottawa.

Pathologist at Yorkton

Dr. Edward J. Andres has been made director of pathology for Yorkton General Hospital, Yorkton, Sask. Dr. Andres, formerly with the department of pathology at the University Hospital, Saskatoon, Sask., was also on the faculty of medicine at the University of Saskatchewan for the past three and a half years. Previously he was associated with the pathology departments of the Saskatoon City Hospital and St. Paul's in Saskatoon.

● Dr. Keith Palmer is the medical director at St. Joseph's new hospital rehabilitation centre, Port Arthur, Ont. Dr. Palmer was formerly senior clinical assistant at the Middlesex Hospital, London, England, a hospital which possesses one of the most active physical medicine departments in the Commonwealth.

● Dr. Francis L. McNaughton has been appointed professor of neurology at McGill University. He has been a staff member of the Montreal Neurological Institute in Montreal since 1935.

● The Brant Sanatorium, Brantford, Ont., has appointed Annie Greig as superintendent of nurses to succeed Millie Turner, who recently resigned from that post.

● Dr. A. J. Caron succeeds Dr. Robert Lamonde as president of the executive committee of the medical bureau of the Hôpital Hôtel Dieu, Sorel, Que.

● Dr. Yvan Jinchereau has been named medical director of the new St-Raymond Hospital, St-Raymond, Que.

● Joseph Gombkoto, who came to Canada from Hungary in 1950, is executive housekeeper at the Winnipeg General Hospital, Winnipeg, Man. Mr. Gombkoto who speaks many languages, has taken the A.H.A.'s Housekeeping Course in Michigan and was formerly at the Hamilton Sanatorium, Hamilton, Ont.

● Dr Frank Chirco of North Bay, Ont., has been named full-time medical superintendent of St. Joseph's Hospital there. He is the first such officer of either hospital in North Bay.

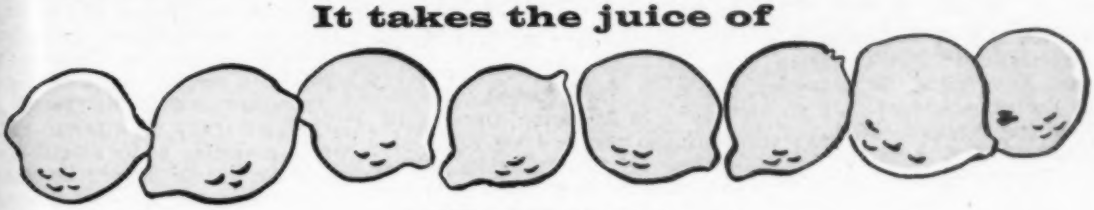
● New laundry director at the Winnipeg General Hospital is Craig Bishop, who comes to this post from the Queen Elizabeth in Montreal, Que. He succeeds William Fisher who has retired from the Winnipeg laundry after 35 years there.

(see also page 32)

Moved

The American Hospital Association has moved into its new nine-storey building. The address is now 840 North Lake Shore Drive, Chicago 11, Ill. The Blue Cross Commission and the American College of Hospital Administrators, who are to share the premises as tenants, plan to move in soon.

It takes the juice of



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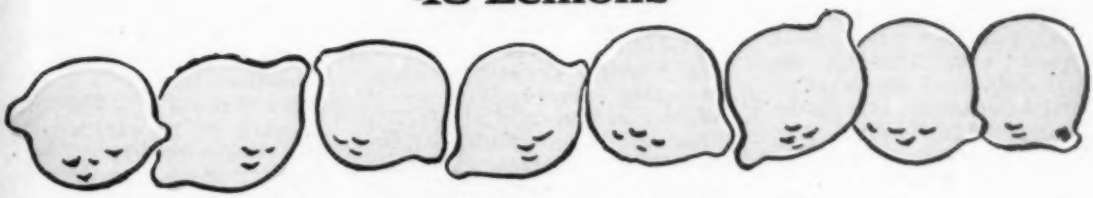

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p.27-30 adv.

To Receive

Stephens Memorial Award

ON BEHALF of the board of directors of the Canadian Hospital Association, Dr. Donald F. W. Porter, president, has announced that Angus C. McGugan, M.D., superintendent of the University of Alberta Hospital, Edmonton, Alberta, has been named as recipient of the George Findlay Stephens Memorial Award for the year 1959. The presentation is planned for May 12, during the biennial meeting of the Canadian Hospital Association, at the Queen Elizabeth Hotel in Montreal, Quebec.

The Award

This award, established in memory of the late Dr. George Findlay Stephens, is bestowed in recognition of noteworthy service in the hospital field in Canada. Dr. Stephens died in April 1948, after a lifetime of serving Canadian hospitals. During his career, he administered two of Canada's leading hospitals—the Winnipeg General in Manitoba, and the Royal Victoria in Montreal. In 1932-33 he was president of the American Hospital Association, the first of two Canadians to hold that office. He was a charter member of the American College of Hospital Administrators, and for six years, from 1939 to 1945, Dr. Stephens was president of the Canadian Hospital Association, then called "The Canadian Hospital Council". During these years extensive demands were made upon him, particularly in solving the many problems created by the second world war. He was regarded as one of the outstanding authorities on hospital administration on the North American continent. In 1946 the American Hospital Association's Award of Merit for exceptional services was conferred upon Dr. Stephens.

Former recipients of the George Findlay Stephens Award are: the late Dr. A. K. Haywood, Vancouver; the late Dr. Fred W. Routley, Toronto; Dr. A. Lorne Gilday, Montreal; Dr. Andrew F. Anderson, Edmonton; Dr. G. Harvey Agnew, Toronto; A. J. Swanson, Toronto; Percy Ward, Vancouver; Rev. Mother Ignatius, Antigonish; R. Fraser Armstrong, Kingston; and J. H. Roy, Montreal.

The Recipient

Born in Alvinston, Ontario, Dr. McGugan received his early education in that province. After teaching in Saskatchewan and in Alberta, he attended the School of Medicine at the University of Alberta, from which he graduated in 1929. From 1930 to 1935 he was director, Division of Communicable Disease, Province of Alberta, and in 1935 obtained a diploma in public health from the University of Toronto. That same year he became medical officer of the provincial mental hospital at Ponoka, Alberta. He remained there for three years and then was appointed medical inspector of hospitals and assistant deputy minister of health, Province of Alberta. In 1942 he assumed his present position as superintendent of the University of Alberta Hospital in Edmonton.

A. C. McGugan, M.D.

Dr. McGugan has always contributed his time and effort generously to many organizations, both in the hospital field and in the community. He has an abiding interest in education *per se*. For many years he served on the board of directors of the Associated Hospitals of Alberta (for two terms was its president); and his aim has ever been to make the association an effective instrument for the improvement of hospital administration. In a wider field his interest in education led him to serve for nine years as general co-ordinator of the Western Canada Institute for Hospital Administrators and Trustees. He is also a member of the board of governors and of the senate of the University of Alberta, and a past president of its alumni association. For a decade he was a member of the board of directors of the Canadian Hospital Association, was its president from 1953 to 1955, and for some years a member of its committee on education.

Dr. McGugan's constant interest in public welfare was shown by his leadership in establishing local prepayment hospital insurance plans and his election as chairman of the first board of trustees of the Alberta Blue Cross plan. He likewise keeps abreast of the times in epidemiology.

His activities have extended beyond the international border as well. He is a fellow and former regent of the American College of Hospital Administrators, a past member of the house of delegates and of the Council on Association Services of the American Hospital Association.

Dr. McGugan is also endowed with literary talent, and has a meticulous command of words combined with skilled imagery. His contributions to hospital and medical literature have been numerous and highly appreciated.

He guided the destiny of the University of Alberta Hospital through the difficult period of the second world war and into a vast expansion program immediately afterward. The latter culminated in the opening last year of a large rehabilitation wing, together with expanded psychiatric services. The hospital, having achieved a capacity of over 1,000 beds, now requires extended service facilities and another wing is under construction to provide space for them.

All of these interests and activities mark Dr. McGugan as an outstanding administrator. It was in 1955 that the Associated Hospitals of Alberta honoured him with a citation in recognition of his services to the hospital field; and the George Findlay Stephens Memorial Award is further evidence of the high regard in which he is held throughout Canada. ■

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Tomorrow's Triumph

EVERY day in Canada the wheels of industry step up their tempo; and every day, in spite of safety programs and carefully designed equipment, the accident toll brings hundreds of men and women under the care of compensation boards or other organizations. A large percentage of injuries are minor, others require long-term treatment, rehabilitation, and sometimes a complete change of vocation.

In this issue we feature Ontario's new Workmen's Compensation Board Hospital and Rehabilitation Centre which is situated in the community of Downsview on the outskirts of Toronto. Replacing the old centre at Malton which has now been razed, the present institution is one of the most advanced of its type to be found anywhere. It has as its motto "Today's adversity can be tomorrow's triumph" and the total rehabilitation of the injured workman is the ultimate goal of all treatment and activity there. Patients are urged to direct their mental efforts toward mapping out their own futures, with guidance and help. Constructive thinking thus replaces worry and prevents the development of neuroses. The staff at the Centre consider it an integral part of their work to set an example of industriousness and cheerfulness; while at the same time they exhibit sympathetic understanding and confidence. Visitors to the Centre are invariably impressed by the evidence of high morale among patients and staff alike—a fine accomplishment in an institution specifically designed to accommodate the most seriously injured workmen.

The philosophy behind the work of this great Centre is perhaps best expressed by Commissioner Dr. E. C. Steele in the words: "The healthy workman is a national asset. The injured workman is a national loss. Government as represented by the people, industry as represented by management, and labour as represented by the unions, endorse the policy of providing the most skilled medical care for those who are hurt on the production front. It is our duty to the province and to the nation to do everything in our power to carry this policy to completion . . ."

Besides the Centre at Downsview the province of Ontario is served by several large and small rehabilitation units which have been established by public agencies. One of the newest is a large department at St. Joseph's Hospital in Port Arthur, the first in the lakehead region.

Likewise the emphasis on rehabilitation has been spreading from coast to coast for several years, each province developing such services either in independent institutions or as departments of large general hospitals. With the coming of eight government sponsored hospital insurance plans, all of which to some degree cover long-term illness, the trend is further heightened. The application of rehabilitation principles minimizes the need for costly care in overcrowded active treatment hospitals and encourages the independence of handicapped individuals—surely a great humanitarian incentive.—*J.F.*

Nursing education today and tomorrow

THE shortage of nurses has always been a topic for agitated discussion. At present we are not hearing quite so much about it as during and immediately after the war years, but we recently discovered that the hospitals in one Canadian city will be looking for 400 additional nurses over the next few years.

With the increasing population and the advent of a national hospital insurance program, the general

public has grown more aware of the value of good health. The demand for more nursing service will continue to grow both in the hospital and the community.

Although we do not know of any recent surveys which indicate the percentage of high school graduates who enter nursing schools each year, a provincial survey done a few years ago revealed that approximately 10 per cent of the high school graduates there entered nursing schools. Because of the heavy demand of other vocations, including teaching, some people believe that 10 per cent may be regarded as nursing's fair share. We are not prepared to labour this point, but we do question whether our nursing schools are geared to meet the increasing number of applicants (the result of a higher birth rate since 1940) which they will soon be asked to train. Already many schools are receiving more applications. Educational institutions and their leaders have been talking for some time about the coming crisis caused by the expected heavy demand on their facilities. Are our nursing schools ready? Sufficient well-trained instructors, extra class room and residence accommodation are needed.

What should be done about nursing education? The views are varied. At one extreme are those who believe that nursing education should be completely divorced from hospitals; at the other are those who still hold to the opinion that the nurse's education is incidental to the service she gives. We believe the great majority do not subscribe to either of these extremes.

Naturally most of the discussion on nursing education has come from the nurses themselves. The Canadian Nurses' Association has recently issued *Policies Regarding Nursing Service and Nursing Education.* We recommend a careful study of this pamphlet. Here are the five basic points the C.N.A. sets out on nursing education: "1. The preparation of the nurse should be an educational experience and the method by which this can best be achieved is through a school which plans and controls the complete experience of the students. 2. The education of all categories of nursing personnel is the responsibility of the professional group. 3. The curriculum for the preparation of any category of nursing personnel should be an evolving one, subject to continuous review. 4. All those charged directly or indirectly with the education of students should be specially qualified, both professionally and personally, for their responsibilities. 5. Nursing requires and has the right to expect public and private financial support of its education."

Throughout Canada most nursing education is being given in hospital schools. We believe the time is overdue for hospital boards, administrators, directors of schools, hospital, nursing and medical associations to sit down together and decide if our present system of educating nurses and the facilities available are adequate for today's and tomorrow's needs.

In-service programs

EVIDENCE of an increasing awareness of the importance of educational programs for all types of hospital personnel is to be seen at every hand. Boards of trustees, administrators, department heads, hospital associations, provincial departments of health, hospital commissions and the federal government are participating more and more. Recently individual Canadian hospitals have been taking a noticeable interest in the development of in-service educational programs. This is encouraging, because despite the high value of formal programs in universities, extension courses, institutes and convention programs, the roots of hospital training programs must lie within the four walls of the hospital itself. We are delighted not only with the increasing interest within hospitals, but with the larger number of university courses being offered, and with the greater number of applicants for our own extension courses in hospital organization and management and for medical record librarians. We are pleased, too, with the attendance at institutes being held across Canada at this time and with the high calibre of the educational programs being offered by provincial hospital associations at their conventions.

At a recent meeting of the Committee on Education of the Canadian Hospital Association the question of how best our national association can assist provincial hospital associations in guiding their member hospitals in the field of in-service training was thoroughly reviewed. After the committee had discussed the many possibilities, they asked the executive staff of the C.H.A. to give top priority to in-service training.

For some time the Canadian Nurses' Association and the Canadian Hospital Association have been discussing the advisability of the two national organizations jointly sponsoring a study course for head nurses and supervisors. These discussions have now reached the stage where both organizations have appointed small committees which will meet jointly to decide on course forms, curriculum content and related matters.

Many other groups within the hospital, through their own organizations, are placing more emphasis on training for their members. We believe all this educational activity is good—for the patient, for the staff and for the community. Certainly the increasing complexity of hospital operation calls for a continuing improvement in the technical knowledge and the arts and skills of all who work there.

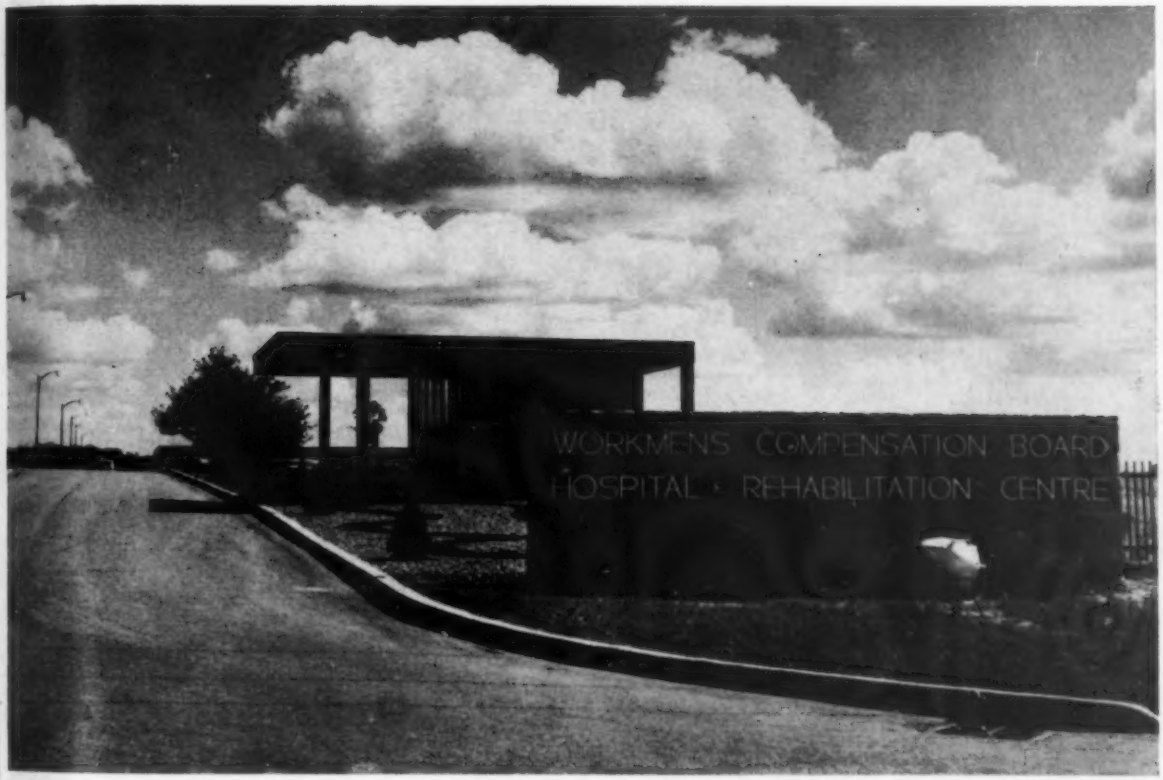
See you in Montreal

THE 15th biennial meeting of the Canadian Hospital Association will be held at the Queen Elizabeth Hotel, Montreal, May 11 to 13. The Catholic Hospital Association of Canada will meet immediately prior to the biennial meeting of the C.H.A. and the meeting of the National Council of Hospital Auxiliaries of Canada will run concurrently.

Although voting at the assembly meetings of the C.H.A. is limited to the official delegates from active members, anyone from the health field is more than welcome to attend all sessions. There will also be several general sessions where topics of broad interest will be discussed, including nursing service and nursing education, accreditation, hospital insurance, institutes and extension course programs. In addition to hospital administrators and trustees, a number of government officials from health and allied departments will participate as well as representatives from our associate members.

On Tuesday evening, May 12, a banquet will be held when Dr. A. C. McGugan will receive the George Findlay Stephens Memorial Award (see page 32) and all living past presidents of the C.H.A. will be presented with a past president's pin in recognition of their services to the association. Plan now to attend the meeting of your national association.

Where injured industrial workmen receive treatment and guidance



fourteen miles from downtown Toronto at Downsview, Ontario

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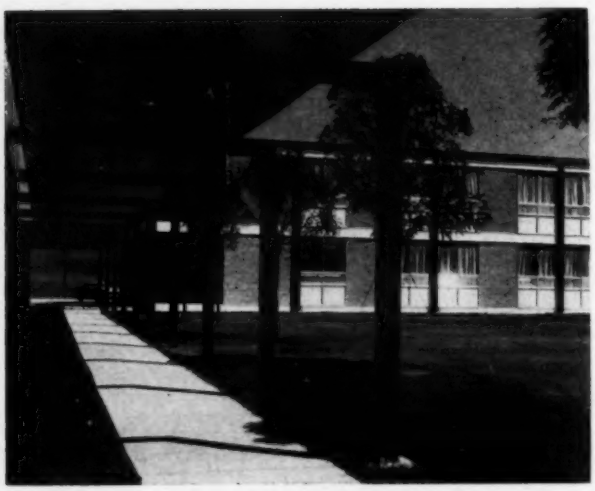


The nurses' residence

Hospital, dormitory, wing and bridge

W. C. B. Centre

Objectives

THE objectives and function of the hospital and rehabilitation centre are, of course, "to return the injured workman to his family and job, in the shortest possible time, and with the least permanent disability."

In addition to the monetary benefits of compensation in lieu of wages, The Workmen's Compensation Board, Ontario, has developed a program of medical care and vocational rehabilitation designed to assist the injured workman in his return to his place in society.

The development of this program is the responsibility of the rehabilitation and treatment services committee, established by the Board to integrate and co-ordinate the operations of the three departments concerned—the medical department, the vocational rehabilitation department, and the hospital and rehabilitation centre. The objective is to produce a smoothly-operating program of quality and quantity controlled medical care, integrated with vocational counselling and job placement assistance when necessary. The hospital and rehabilitation centre occupies a mid-position between these two departments. The medical and treatment staff, with the division of the vocational rehabilitation department give supervised convalescent care and a six and one-half hour daily physical restoration program to the more serious cases. The vocational rehabilitation officer carries out vocational and social inquiry and counselling.

The less seriously injured patients will remain in their own communities for further treatment if an adequate service can be provided there. However, about five per cent of compensation cases represent serious problems of physical restoration or vocational rehabilitation. They require a more extensive service and a longer treatment day than is usually available in local facilities. These cases require the total rehabilitation service, or a major part of it, and this is supplied at the W.C.B. Hospital and Rehabilitation Centre in Downsview on the outskirts of Toronto.

Thus the objective of the Centre is to provide a total rehabilitation

The names of the authors of this series will appear at the end of each section.

service to the extent required by the case, by co-ordinating the medically-controlled program of physical restoration with the needed services of vocational rehabilitation and job placement assistance, within the policies of the Board and to the extent permitted by the Workmen's Compensation Act, Ontario.

The Hospital and Rehabilitation Centre has two principal treatment areas—the hospital and clinic sections. The hospital section has accommodation and nursing services for 175 bed patients. If the patient can get up, either by himself or on crutches or wheelchair, he goes to the clinic treatment area for his physical medicine treatment. The clinic section is the main treatment area for physical and occupational therapy and remedial gymnastics. In addition, there is dormitory accommodation for 340 patients and locker accommodation for 50 out-patients.

Thus, during recovery, a patient may start in a community general hospital, be transferred to the Centre's hospital section for convalescence, then to the clinic section for up-patient treatment, and finally to the out-patient status, if his home locality permits it.

Convalescent care is given in the hospital section and physical restoration in the physical and occupational therapy departments as well as in the department of remedial gymnastics. Physical evaluation is given by the occupational therapy department and vocational counselling and evaluation is done by the rehabilitation division.

The treatment policy of the Centre is based upon specific treatment required for the injury, and upon controlled activity developed specifically for the patient and his disability by a treatment team. When admitted, the patient is placed under the care of a medical doctor, who is responsible for confirmation of diagnosis, and the development of a treatment program for the specific patient. He is the head of the team, whose other members are the physical and occupational therapists, the remedial gymnast and the vocational rehabilitation officer. The patient, himself, must also be a co-operative member of this team, as he must understand his disabilities and the reasons for the treatments which have been ordered for him. Without his co-operation the difficulties of treatment are greatly magnified and, indeed, may be insurmountable.

The members of the treatment team meet weekly to discuss their cases, the progress or difficulties encountered with specific patients. The patient himself is not necessarily at this meeting as this would hamper free discussion among the members of the team. However, this team approach makes it possible to develop a specific treatment program for the patient and to vary this program as progress or difficulties arise. It also permits a better over-all knowledge of the patient and his reaction, so that members of the team understand their patient, and can discuss his problems with him.

There are ten such teams in the hospital and rehabilitation centre. To co-ordinate their activities, and to develop uniform policies and practices, weekly meetings of the medical staff, the treatment supervisors, and the treatment departments themselves, are held. These allow a free flow of information among the staff to further the development of sound policies and practices.

One of the treatment teams is the medical rehabilitation unit. This is organized to handle special problems in physical and vocational evaluation, *e.g.*, when the workman has been discharged and considered fit for work, but circumstances later indicate that he is unable to do so. In addition, the unit handles problems presented by a block to recovery from psychological or psychosomatic factors.

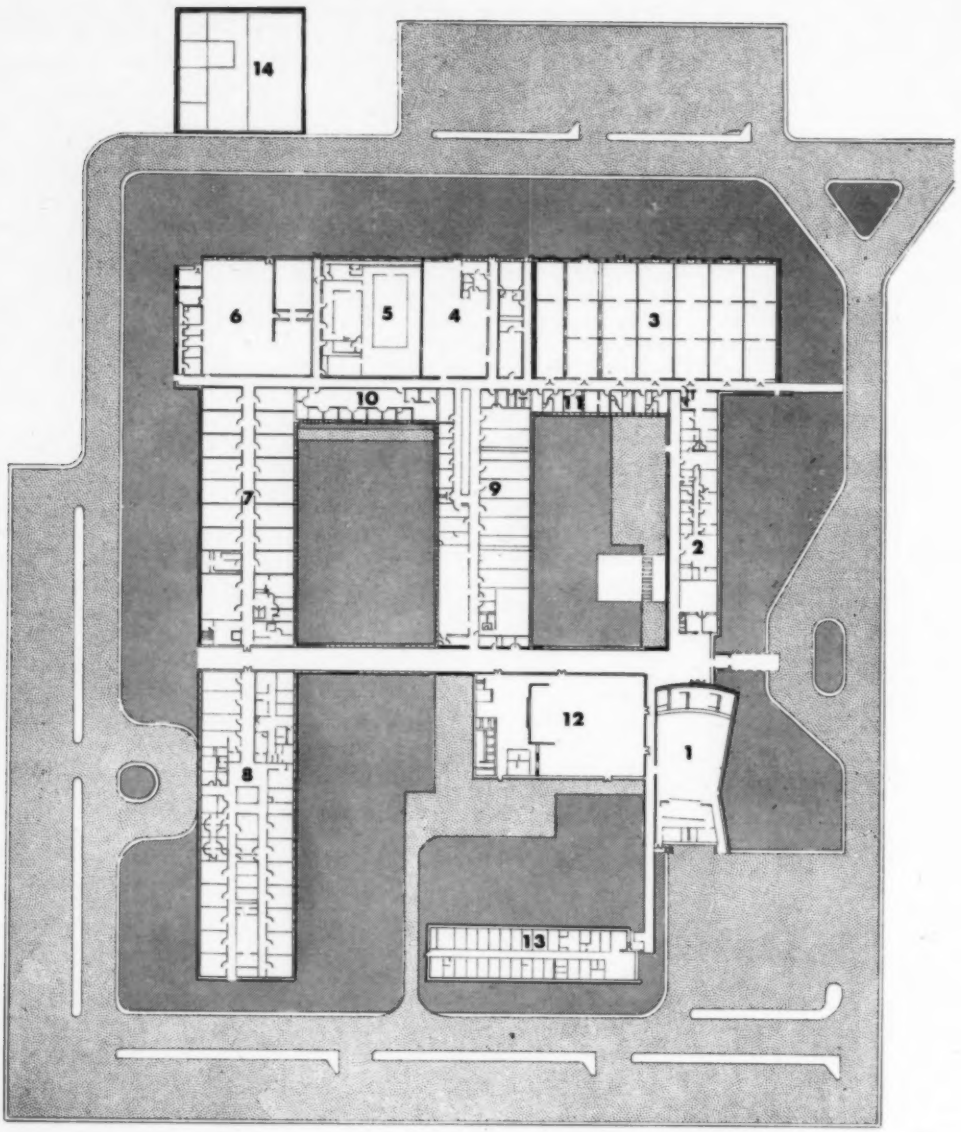
The Centre was designed and functions to assist the workman who is injured as the result of an industrial accident. The friendly and helpful atmosphere created by the staff is essential to gain his confidence and co-operation. Without these the Centre cannot demonstrate its motto: "Today's adversity can be tomorrow's triumph"—*B. H. E. Curry, M.D., medical director.*

Structure and materials

THE requirements for the new Workmen's Compensation Board Centre, based on ten years' experience in temporary housing at Malton, were easy circulation, flexibility, durable building materials and accommodation for 500 patients. Intensive research and many hours of discussion produced the design for a building of 314,000 square feet, mostly on one floor level, which accommodates all patient areas under one roof.

The main building houses the administration, auditorium, dining rooms and kitchen, occupational therapy, physiotherapy, a

A landscaped interior court



Key to Plan

1. Auditorium—capacity 500.
2. Administration, admitting and discharge offices
3. Occupational therapy
4. Central stores
5. Therapy pool
6. General gymnasium, amputee gymnasium, heavy resistance room
7. Clinic dormitories—325 beds
8. Hospital—175 beds
9. Physiotherapy—56 plinth tables
10. Rehabilitation, vocational and claims offices
11. Clinic doctors and secretaries
12. Kitchen, service area and staff and patients' dining rooms
13. Nurses' residence
14. Garages, maintenance shops. heating plant.

hospital wing with 175 beds for non-ambulant patients, a dormitory wing with 325 beds for ambulant patients and a recreation area.

The boiler room and maintenance workshops are in a separate building which is connected to the main building by a tunnel containing all pipes and lines for steam, hot water, cold water, and electrical services. During inclement weather this tunnel may also be used for the transportation of materials and goods to and from the maintenance shops.

The third building contains apartments for resident nurses, student nurses, orderlies and doctors. These apartments are all private bed-sitting rooms, with one bathroom for every two nurses' apartments; a private bathroom for each doctor's apartment; and a communal bathroom for a group of six student nurses; and one for six orderlies. Separate lounges and kitchens are also provided for each group. There is one general lounge which is two storeys high and has a large brick fireplace. The floor in this room is of cut slate which continues through the ground floor corridor. It has good texture and colour and is easy to keep clean. Other floors are covered with linoleum or vinyl asbestos tile for resilience.

From the nurses' residence one walks to the main building along a covered concrete walk-way through one of the landscaped courts to arrive at the dining room block. Two separate dining rooms provide room for patients and staff. The adjoining rooms are separated from each other by a wood folding screen which may be opened on special occasions so that one large room is formed. Daylight is admitted to the dining rooms through continuous windows on the long sides of the rooms and from clerestorey windows. The former give pleasant views of the landscaped courts. Artificial light is not needed during the daytime.

Food for both dining rooms is prepared in one large modern kitchen which has quarry tile flooring, glazed tile walls and metal acoustic tile. All equipment is stainless steel. Walk-in refrigerators, a walk-in deep freeze, a dishwasher and pressure cookers make this kitchen a highly efficient unit. At the fully equipped stainless steel counters a self-service system is used.

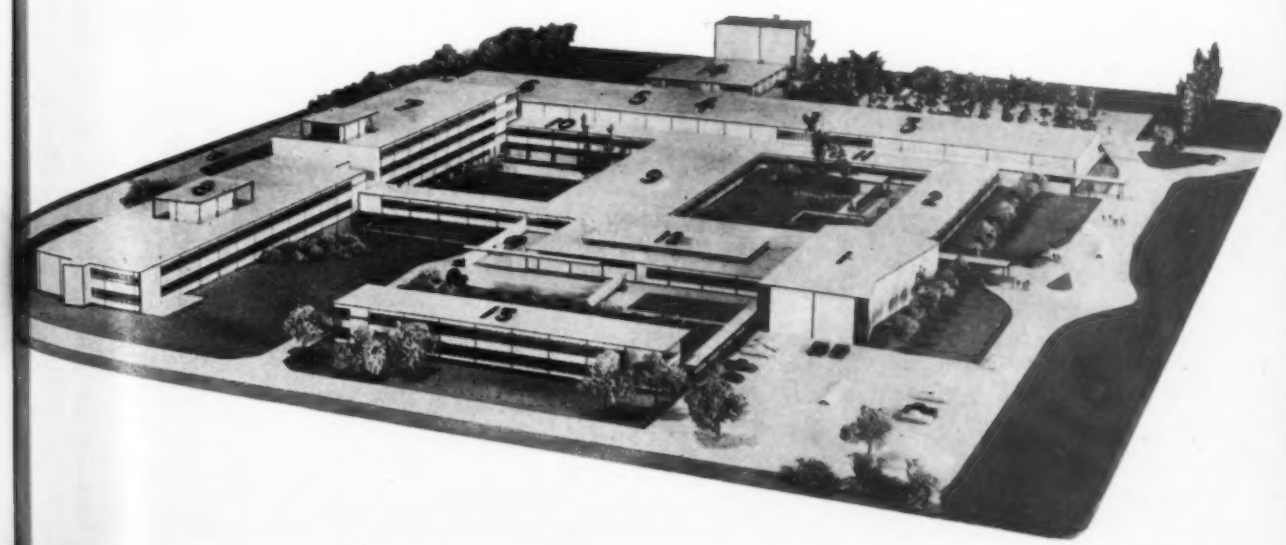
At the end of the dining room corridor is a foyer which is the main entrance to the building. The floor is terrazzo with strips of contrasting colour, accentuating the 3′ 6″ module on which all the buildings were designed. The walls are patterned brick and the ceiling, a reflection of the floor pattern, is of acoustic material. A walnut screen and some walnut planting boxes divide the space to provide seating areas for waiting visitors. Two interesting works of metal sculpture, by Helen Robertson, adorn the area.

From the foyer there is direct access to the auditorium which seats 500 people in comfortable pre-formed plywood nesting chairs. The auditorium was designed as a dual purpose room. It provides complete theatre and movie facilities for patients and staff, and it can be converted quickly into a convention hall. For this reason the floor is level rather than sloping and the chairs, specially designed for this project, can be stacked and put out of the way under the stage to leave ample room for conventions or dances.

Movie equipment consists of two 16 mm sound projectors set up in the projection booth, a high fidelity speaker box and a movable wide screen. Stage equipment comprises overhead lighting banks, spotlights and the necessary back drops—thus giving the

Architects:

Page and Steele
Thomas R. Wiley and Associates
Toronto, Ontario



professional groups, which visit the Centre from time to time, all the facilities to put on a high grade performance.

The design of the auditorium has been kept very simple so that it will not detract from what takes place on the stage. The floor is of a composition wood block requiring a minimum of maintenance. The back wall is covered in perforated acoustical material, the side walls are plastered, and terminate into two curved walnut screens flanking the stage and leading up to it.

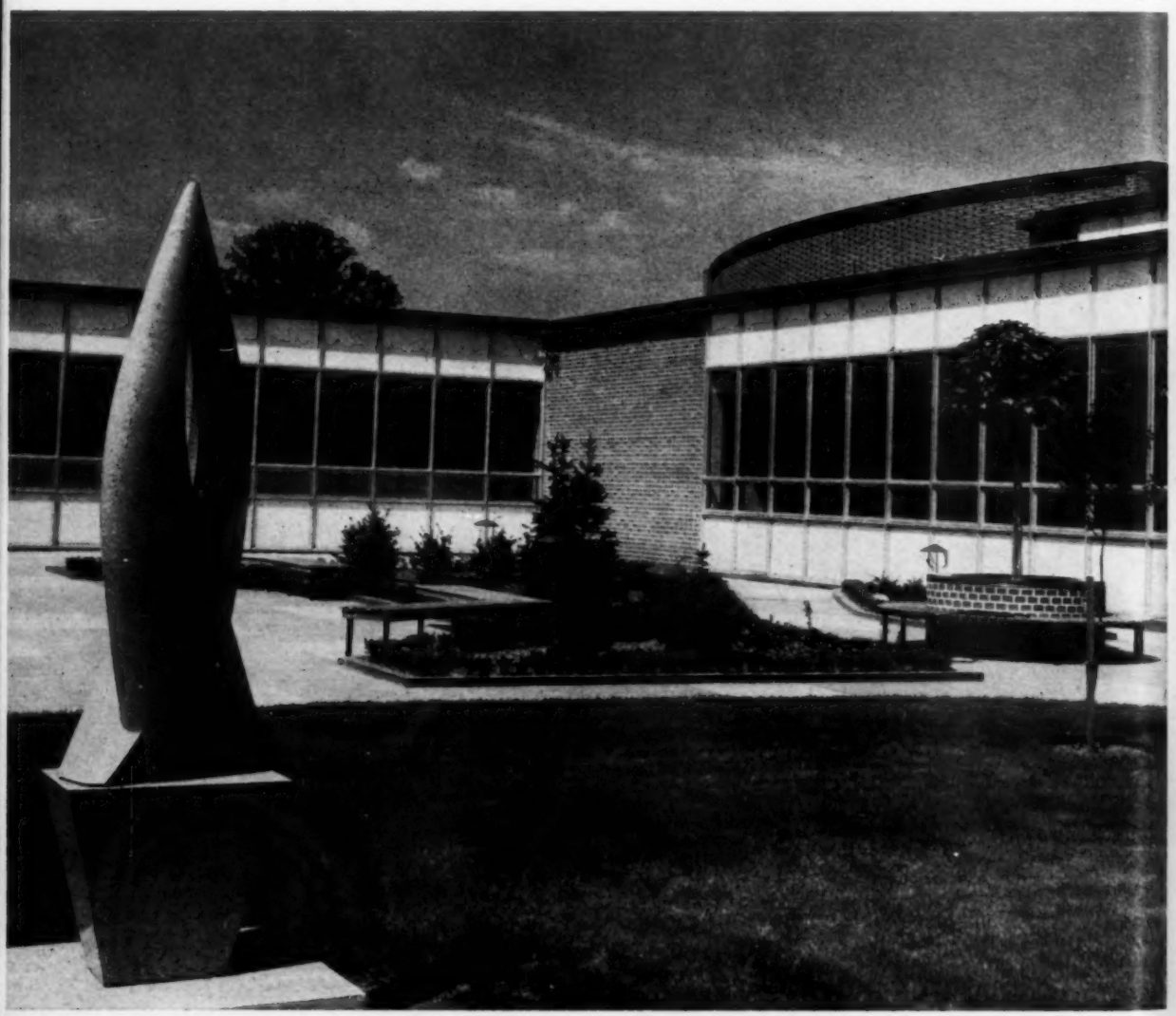
On the other side of the foyer is the administration wing, containing all the offices necessary for the running of the Centre. The floor covering is vinyl asbestos. The walls are plastered and the ceilings are acoustic tile. From the administration wing there is direct access to the treatment areas which are all on one floor to ensure the best possible circulation of disabled persons.

The occupational therapy wing was designed to simulate industrial environments: all structural materials are left exposed — the concrete floor, the steel framing, the smooth red tile walls and the precast concrete roof structure give the desired effect. The 105′ x 220′ area is divided into seven equal parts by 7′ high metal shelving units in which the tools and materials that are used in the treatment work are stored.

Off the occupational therapy wing is the physiotherapy wing. This wing contains eight wards for massage and heat treatment and two rooms for hydrotherapy. The wards have linoleum floors, plaster walls and acoustic tile ceilings to cut noise. The hydrotherapy rooms have quarry tile floors, glazed tile walls and plaster ceilings. The wax and whirlpool baths are of stainless steel.

In this same wing are located also the lounges and locker rooms for the treatment staff and a lecture room which doubles as a chapel on Sundays. Next to this room is a small reference library, designed for staff use. The staff lounge is divided into two sections by a folding partition; one section used by women; the other

The administration court is attractively landscaped



by men. On special occasions the partition may be folded back to give one big space.

From the physiotherapy department a wide rubber-covered ramp leads down to an experimental treatment area. A ramp, rather than stairs or an elevator, was specified to provide for walking exercises during inclement weather.

An orthopaedic pool is on the other side of the physiotherapy wing. The size of the basin is 30′ by 66′ and it varies in depth from 3′ 6″ to 5′ 6″. The water is level with the surrounding floor which enables easy manipulation of patients. The temperature of both the water and the air is kept at approximately 80°F. A wide apron on one side of the tank gives an area for "dry" exercise.

Metal sculpture by Helen Robertson

↑ *Main foyer*

Reflecting pool ↓

Access to the pool is by means of two easy stairs or, for amputee or wheelchair patients, by a mono-rail which enables a patient to be lowered gently into the water. The multi-coloured ceramic tile covering of the pool is continued on the aprons in "anti-slip" ceramic tile. The walls continue the same colour scheme in glazed tile, giving the space a very festive and gay aspect. Three metal acoustical panels are suspended from the plaster ceiling to reduce the noise as much as possible. An observation booth, separating the pool from the corridor, gives visitors an opportunity to observe the activity in the pool through double glazing without disturbing the hygienic conditions in that area.

The locker room next to the pool serves both the pool and three adjoining gymnasia. Floors are quarry tile and the walls glazed tile like the attached shower room. The shower room is equipped with a multi-head walk-through shower, ensuring quick circulation.

The gymnasia have composition wood block flooring similar to the auditorium, the dining rooms and the recreation area. The walls are exposed brick and smooth red tile; the ceilings are acoustic tile.

The dormitory and hospital wings, being multi-storey buildings, had to be fireproof structures, and therefore a concrete skeleton was used rather than a fireproofed steel one. The dor-

mitory "basement" which faces out onto a large sunken grass court, is occupied by the recreation area. This is for the use of ambulant patients outside "working hours", and is divided into sections for reading and writing, table tennis, pool, card playing and shuffleboard. There is also a canteen where light snacks may be had. As mentioned before, the floors are composition wood block, the walls structural glazed tile and the ceiling suspended acoustic tile.

The first and second floors of the dormitory block contain eight-bed wards on either side of the single corridor. The third floor of this block contains six-bed wards, and a central service core with a corridor on both sides. This is the system used in the two storey hospital block. The service core contains washrooms, utility rooms, nurses' stations and storage rooms. The reason for making this floor identical to the hospital floors was to provide for a possible changing ratio of ambulant and non-ambulant patients.

The hospital block, a two storey building, is designed for an additional third storey. The lay-out is the same as the third storey of the dormitory block. The hospital block includes, however, an x-ray suite which comprises two radiography rooms and one fluoroscopy room, dressing rooms, a dark room and offices. For extreme resilience the floor is covered with rubber tile.

The operating room, intended for the time being for minor surgery only, may be converted into a complete operating room since the suite contains a recovery room, two anaesthetic gas storage rooms, sterilizing rooms and a laboratory. The operating room has a conductive vinyl floor, glazed tile walls and a metal acoustic tile ceiling.

Main entrance and auditorium

The plaster cast room and the dispensary have quarry tile floors, painted tile walls, and plaster ceilings. The wards have vinyl asbestos or linoleum floors, plaster walls and ceilings. The bases are sloping terrazzo to prevent the beds from striking the walls. Cupboards and lockers are built-in against the corridor walls, reducing traffic noise transmission to a minimum.

The corridors in the hospital and dormitory blocks have sloping terrazzo bases. All corridors throughout the centre have vinyl asbestos or linoleum floors structural glazed tile walls and acoustic tile ceilings. Stairs have non-slip rubber treads and crutch stops. The crutch stop is formed by a raised edge on each tread which prevents a crutch from slipping off. The dormitory and hospital blocks are each equipped with one self operated elevator, which is completely automatic and large enough to take stretchers and hospital beds.

The washrooms have ceramic tile floors, glazed tile walls and plaster ceilings and all have facilities for wheelchair patients. A number of wash basins are spaced at a height to suit wheelchair patients. There are also "drive-in" types of shower and toilet stalls equipped with grab rails and ropes suspended from the ceiling.

The working counters throughout the building are laminated plastic and have stainless steel sinks. Window stools are plastic except in the hospital and dormitory where terrazzo was used. Doors are laminated plastic throughout.

Because of the budget requirements only portions of the building could be fully air-conditioned. These parts include the hospital, doctors' offices, administration wing, dining rooms and the auditorium. Other areas, however, have an air change system which is the next best to full air-conditioning. For the same reasons, double glazing was restricted to the air-conditioned areas. In the administration offices which face west, a special heat-resisting glass was used to reduce the effect of the low west sun.

The exterior of the building shows a large amount of anodized aluminum curtain wall with porcelain enamel panels, aluminum window walls, and brick. Structural steel was left exposed, both in interior and exterior. It was painted a contrasting colour and gives the long corridors and exterior walls a pleasant rhythm. Extensive concrete aprons enable patients to participate in outdoor activities whenever weather conditions permit. A concrete apron at the hospital gives non-ambulant patients a chance to enjoy the sun for they can be wheeled out on stretchers without difficulty. The sunken grass court adjoining the recreation area gives plenty of opportunity for outdoor games such as badminton and volley ball and other sports.

Landscaping of the interior courts and immediate surroundings of the building is extensive and gives the large grounds a park-like appearance which contributes greatly to the success of the project architecturally.—*Peter D. J. Tirion, for Page & Steele, Architects, and Thomas R. Wiley, Associated Architects.*

Hospital section

THE hospital is a modern, red brick and aluminum sash, two-storey building situated in the northeast wing of the Centre. It is the only hospital on this continent devoted solely to treatment and physical rehabilitation of the industrially injured workman.

The floor area of the hospital covers 46,750 square feet and the bed capacity is 175. Surgical treatment is not performed here, but the patient is brought in as soon after surgery as he can withstand transportation by ambulance. The professional staff is qualified to take over the severely injured from the post-operative stage and carry him through until he is fit to be transferred to the clinic section.

The ground floor is entered from the spacious main corridor through a large, double, swinging door. The radiology department occupies a portion of the ground floor and is equipped with two 300 MA diagnostic units and with one image amplifier fluoroscope. The darkroom is between the two diagnostic rooms. The dressing rooms are divided by plywood walls and curtains. The office of the radiologist, the radiographer, and the x-ray stenographer, complete this self-contained department.

Opposite the radiology department is the pharmacy and medical stores which have ample space to store drugs and necessary hospital supplies. Adjoining this is the cast room equipped with an orthopaedic table. Here all plaster work as well as pylons for our amputees, splints, and other orthopaedic appliances are made by two specially trained plaster technicians.

Further down the corridor is the emergency operating room with a small scrub room and recovery room. Adjoining is the autoclave and sterile supply room, and a small laboratory.

The nursing superintendent's and the security officers' offices are by the ambulance entrance.

The ground floor nursing station is glassed in on three sides and is connected with each ward by an inter-com system which is a great step saver for the nurses. The ward kitchen, orderlies' utility room, storage room, and the spacious bathrooms for patients form a core area between the double corridors, with the wards on the outside. The ground floor has nine six-bed wards plus two isolation units with three single-bed rooms each, making a total of 60 beds. The patients' lounge is furnished with modern armchairs and tables. There is an easily accessible, large, cement terrace on each side of the hospital wing, and patients may be wheeled out on sunny days for fresh air and sunshine.

An elevator and a stairway connect the ground floor with the second floor. Here are 20 wards with 120 beds. The amputation patients fill several of these wards.

Admittance and discharge

Two nursing stations, two ward kitchens, utility rooms, and patients' bathrooms again form a central core between the two corridors and the wards.

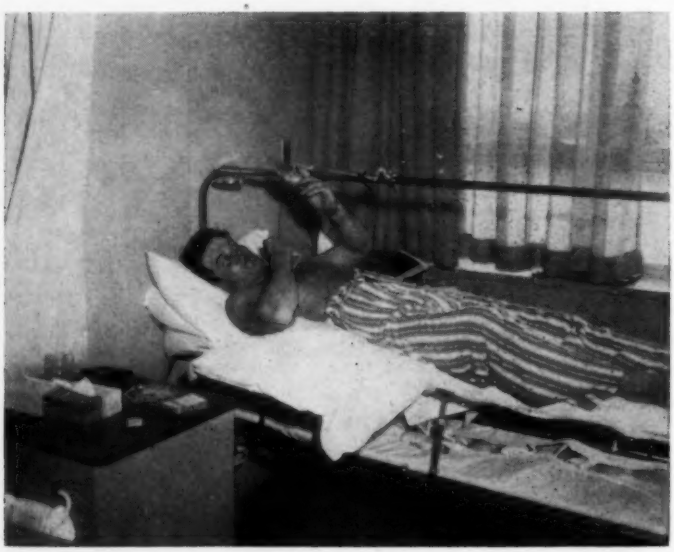
On entering one of the cheerful wards, we see six beds with bedside tables for small personal possessions in daily use. Nylon, tracked curtains, hanging from the ceiling, may be used to give the patient privacy if he so desires. A large, wall-to-wall picture window overlooking a golf and country club provides a picturesque view. Curtains can be drawn to keep out the sun or bright light. Every patient has a clothes locker and there are wall cabinets to keep materials and tools for occupational therapy. Heated food trucks and tray carriers bring food to the patients. Some patients are en-

Another view of the nurses' residence

couraged to go to the dining room as soon as they can manage it.

The second floor also contains four doctors' offices with examining rooms, and an office for the medical secretaries.

A large, comfortably furnished patients' lounge, equipped with television and numerous journals, serves to give a home-like atmosphere. Here the wheelchair and Stryker-frame patients meet with the more fortunate ones who can walk on crutches and canes.



Injured back cases are in Stryker frames, their spines immobilized, thus providing more opportunity for speedy bone growth and the knitting of injured parts. Patient is using an electric razor.

A team of nurses, physiotherapists, occupational therapists, remedial gymnasts, recreation officers, and rehabilitation officers work together to the fullest possible extent in order to bring the best and fastest recovery to the injured man.

The hospital section is designed to provide convalescence and physical rehabilitation. It is the second step in recovery, from general hospital to convalescence to up-patient and then out-patient, and finally to the return to work. It is the aim to have the patient transferred as soon as is reasonable from the general hospital to the hospital section of the Centre so that the program of physical rehabilitation can be started at once to the extent permitted by the patient's condition. Activity is the key-note. Thus, if the patient can go to the clinic treatment area by wheelchair, crutches or canes he does so rather than have the treatment brought to him. The same applies to meals. If he can go to the cafeteria he is not fed in bed.

Skilled nursing services plus physical and occupational therapy are supplied on the ward for bed patients. Weekly ward rounds by the doctor, and by the nurse, physical and occupational therapist, and vocational officer bring the team approach to treatment in the hospital section. As soon as possible, the patient is transferred to the clinic section. — *Dr. P. Traub, medical supervisor, hospital section.*

Physical therapy department

THE extensive facilities and up-to-date equipment in the physical therapy department are the result of years of work and planning. Since 1915 the Board has sought the best possible treatment for injured workmen—and physical therapy is one of the most important elements in that treatment. Dr. D. E. Bell, once chief medical officer, had always been interested in the possibilities of such treatment. In 1930 he visited a physical therapy department in Rochester, N.Y., one of the most advanced in the world at that time, and returned completely convinced that there must be such a department here. At last the first rehabilitation clinic was set up—six treatment rooms and a gymnasium. It was equipped with stall bars, shoulder wheels, an inclined walk, et cetera. Patients came to the clinic every day for about three hours to receive physiotherapy, massage, shortwave and diathermy treatment. The die had been cast.

Today the physical therapy department is one of four responsible for the physical restoration of the injured worker. The others, of course, are the nursing, occupational therapy and remedial gymnastic departments. In order to use the particular skills of both physical therapists and remedial gymnasts efficiently and without duplication, the following policy was adopted toward remedial exercises—the individual exercises are done under the direction of the physical therapist, leaving group exercises and resistance exercises to the remedial gymnasts.

The physical therapy staff consists of a supervisor, two assistant supervisors and 20 staff therapists. Two therapists are assigned to each doctor in the hospital and clinic sections.

Those responsible for the care of hospital patients treat them in the wards or in the department. Patients capable of travelling to the various departments without retarding their progress by the extra effort are expected to do so. The other hospital patients have their treatment in the wards. The hospital therapist spends part of each day in the department and part in the wards. She is a member of the team which makes weekly rounds of the hospital patients.

Patients in the clinic report for treatment to the therapist in the department. A weekly meeting with the clinic doctor gives an opportunity for the exchange of information with the physical and occupational therapists assigned to him.

Physical therapy is prescribed by the medical staff and used mainly in the early stages of treatment to assist patients in overcoming pain, stiffness, weakness and paralysis. As they become capable of a more active regime, the passive modalities are discontinued and emphasis is placed on active exercise performed by the patients. Group activity, resistance exercises and occupational therapy enter the treatment program—these are advanced treatment and, in the end, make up the patient's total treatment.

The physical therapy department consists of an ultra-violet room and ten other treatment rooms. Two of these contain the wax and whirlpool baths and are centrally located. In the other rooms are the treatment plinths, electrical equipment and exercise mirrors. The eight rooms have similar furnishings and are equipped so that each patient may have full use of the facilities.

The therapists use infra red lamps, wax and whirlpool baths, short wave machines, low frequency machines for the production of faradic and galvanic currents, an ultra sound and a microwave machine and exercise frames. These overbed frames, designed so they can be used on treatment plinths and hospital beds alike, provide a stable, functional support for sling and auto-assisted exercises as well as for traction.

The therapeutic pool, located next to the orthopaedic pool, is an original design which incorporates features found in many pools and tanks. Rectangular in shape, it is eight feet by 11 feet, with water depths of three, three and one-half and four feet. A stainless steel railing is permanently fixed around the inside of the pool. Two removable bars divide it into its three depths. Rope and cork floats are used to support the patients during treatment. A stainless steel stool with hollow legs is used for certain activities. The water temperature is maintained between 98 and 100 degrees F. One side of the pool is approximately 20 inches above the floor. This side is used for the entrance and exit of patients and since it approximates the height of a wheelchair seat, it is useful for the patient using a chair. A sunken area on the other sides of the pool eliminates the therapist's having to bend over the pool as she treats her patients. A hoist to lift and support patients is to be installed later.

Two troughs containing hot and cold water are used for contrast baths. They measure eight feet by two feet, with a depth of 18 inches and have a layer of grit or fine gravel on the bottom. This rough surface offers further stimulation to the circulation of the feet and the shifting substance moving under the patient's feet as he walks through the water from one trough to the other means that the small muscles of the feet must do extra work.

The supervisor of physical therapy is responsible for the treatment program office which is staffed by two clerks. They arrange patients' treatment timetables according to the doctors' prescriptions for physical and occupational therapy and remedial gymnastics. They also maintain controls to ensure the efficient use of the Centre's therapeutic equipment. Records are kept to show the location of patients throughout the treatment day. A considerable amount of co-ordination is required to control the programs of the 400-450 patients treated daily in the clinic area.

The physical therapy department, then, makes its major contribution in the early stages of the patient's treatment program, using the modalities on an individual basis to help the patients reach an active state where they can do much to help themselves. — *Joan Pape, physical therapy supervisor.*

Remedial gymnastics department

IN ORDER to prevent overlapping of treatment (although sometimes it is unavoidable and sometimes even desirable) our program has been carefully arranged. The remedial gymnast's rôle has been confined to the supervision of group activities. On the staff are a supervisor, an assistant supervisor, nine gymnasts, a clerical staff and pool attendants.

The department has a main gymnasium large enough (103′ x 62′ x 22′) for four groups or classes from 30 to 40 patients each. The floor is unobstructed by equipment, since all wall fixtures leave a six inch clearance from the floor. The area has controlled heating and ventilation and permits the maximum use of natural and artificial lighting. There are two double exits in case the gymnasium must be cleared in a hurry. The equipment is the kind essential for free, active remedial exercises rather than that usually seen in gymnasia for physical education in schools, et cetera.

The remedial gymnasts conduct classes of patients grouped according to their disabilities. For example, patients with upper extremity injuries are grouped and designated "arm and shoulder"; those with injuries to the trunk are known, when grouped, as "back".

Each group is divided again according to physical performance. Then classes are formed of patients with approximately the same physical capacities and performance capabilities. The free active exer-

In the therapeutic tank weight bearing exercises are supervised.

The remedial gymnast instructs a group working out their joints on specially designed apparatus.

cises are local and general, which involve postural re-education of specific regions.

Each exercise period lasts 30 minutes. Additional time is given for changing into appropriate exercise dress. The exercise time allows for short resting periods between and during activities.

Periods are set aside for competitive team or group games, so popular in the service convalescent hospitals during the wars. These games did a lot to maintain morale and were invaluable when large numbers of men required recreation to keep them physically and mentally occupied during a long convalescent period.

If the weather is good, groups sometimes attend their gymnastic classes outside. Those who do this most often are capable of re-adjusting to the natural terrain and obstacles peculiar to their vocation. Lower extremity training courses with obstacles along the way help in the retraining that will enable a patient to deal with the obstacles he encounters in his daily work—especially the construction and bush workers who make up a large percentage of lower extremity disabilities.

The remedial gymnastic department, in a specially adapted but smaller gymnasium (34′ x 43′), supervises the prescribed progressive resistance exercise program on apparatus designed to suit the needs of the Centre. Much of the apparatus seen in small hospital gymnasia would be totally unsuited to the large patient load here (usually 400-500 daily). For instance, the Delorm system which makes use of metal boots with the resistance in the form of adjustable plate weights takes up far too much time when this adjustment is done by a gymnast. We use the more convenient pulley circuit in which the patient can adjust his resistance for himself by the use of a convenient hook in the circuit.

All resistance exercise is prescribed on an individual basis and it is here that we have departed somewhat from the policy of using the gymnast for group work only. But there is sufficient equipment to group these exercises, so that we are still employing the gymnast for group supervision.

The section also supervises group water activities in the large orthopaedic pool, 66′ x 30′, especially designed and equipped. Temperature control from 70 to 98 degrees F. ensures that the pool can be used for all foreseeable therapeutic purposes. The pool has mono-rail and hoist facilities.

An important rôle of the section is in the pre-prosthetic phase of physical conditioning and in the preparation of the amputee. When he is fitted with a limb, the prosthetic patient is trained in a gymnasium set apart for this purpose.

The gymnast has also worked in the fitting and maintenance of appliances, such as canes, and crutches, and in gait training.—*T. Wells, remedial gymnastics supervisor.*

Special equipment

SINCE the main theme within the Centre is treatment of the injured, most of whom are ambulant, and treatment for most if not all, of the working day, facilities in building and treatment requirements not found in the general or private hospital are brought into use here at the Workmen's Compensation Board Hospital and Rehabilitation Centre. The supply of catalogued equipment able to meet the demands placed by progressive and advancing physical medicine techniques for housing and treating large numbers of patients is limited. It is too individual and expensive to install and maintain. To obtain the maximum value from such equipment, therefore, is hard in our case. The hospital and rehabilitation staff can be credited with eliminating many problems in the equipment now at the Centre.

The present equipment originated in many ways. Through suggestions from both individual people and groups, from production within the Centre's workshop, through manufacture by business firms from our drawings or models to specification, and from the modification of catalogued units, this equipment has been produced. Before any new or modified equipment is placed on order or before production of a trial unit is started, the unit must survive close scrutiny.

No one piece of equipment will be explained in full detail here, nor will all of the equipment in use be listed. Instead a general coverage of some—describing the name, origin, construction, where produced and where applied — will be given.

The Hand, Wrist and Finger Exerciser has been developed in the resistance gymnasium and has been produced in the occupational therapy department by the patients. It is constructed of wood, leather, varying sizes of elastic bands and felt or sponge rubber pads and is used in the resistance gymnasium and physical therapy and hospital sections to supply resistance or assistance to any part or all areas of damaged or mutilated hands, wrist or forearm in the early recovery stage.

The Bed Plinth Frame, developed in the maintenance department, combines the skills of maintenance, remedial gymnastic and physical therapy departments. It is an all-metal construction, chrome plated and is produced by an outside man-

ufacturer. It is easily adaptable to a hospital bed or plinth; and supplies firm fixation for exercise apparatus, sling suspension, patient aids for nursing care, and various traction units. It is in use in the hospital and physical therapy sections. At present added features are being constructed.

Physical Therapy Plinths were developed in the maintenance department in co-operation with the physical therapy department. They are constructed of hardwood and are produced in quantity in the Centre's workshop by staff. Equipped with mattresses and contour sheets the plinth is supplied to the physical therapy department.

The Abduction Frame was developed at the request of the remedial gymnastic staff in co-operation with the Centre's doctors. It is all metal in construction, and is produced by outside technicians to meet our need for a universal type of frame to fill prescription requirements in the treatment of arm and shoulder injuries. This frame is now listed by the manufacturer.

Weaving Looms are purchased from outside manufacturers. They are made of wood and metal, and are modified by the occupational therapy department to supply exercises of a specific nature in upper and lower limb injuries, including amputations.

The Box Car, developed by the occupational therapy department, is of wood and metal and was built by the patients within the Centre. It is equipped with the standard fixtures used in railway car construction: breaking unit, catwalk, ladders, loading doors. It is used by the occupational therapy department in training and testing railroad employees under the conditions they will encounter when they return to work.

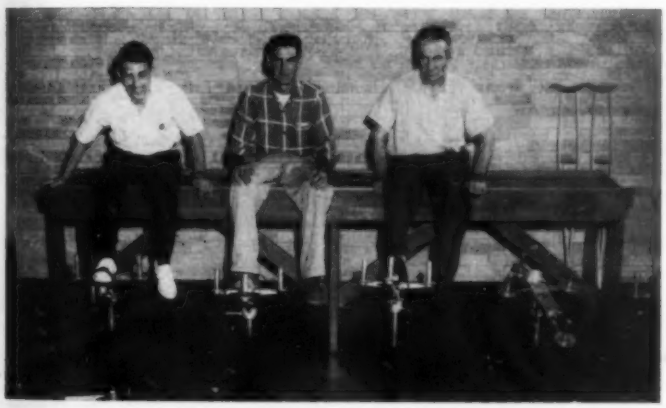
Resisted Quadriceps Exercise Unit, developed under remedial gymnastic department, of wood and metal construction, was produced by the Centre's maintenance staff and outside manufacture. It is in use in the resistance gymnasium, for supplying progressive resistance to the quadricep muscles in a full or limited range of movement. This unit will accommodate ten persons at one time.

Ramp and Stair Units were developed in the remedial gymnastic department in co-operation with the maintenance technicians, and are also made of wood and metal. They are produced in the Centre's workshop by the staff. They are in use in the main and amputee gymnasiums (further units will be introduced into the occupational therapy department.) Each unit has a varying height of steps for progression in retraining, which may be fixed in a complete group or used in individual sections.

Traction Tables, developed by request of the medical director in the remedial gymnastic department, were constructed in the Centre's workshop and are used in the resistance gymnasium to supply an added feature in the treatment of back conditions.

Plaster Pylons, developed within the Centre by the plaster technicians, in close co-operation with medical and treatment staffs, are used extensively in the advancing program of amputee treatment and training.

These pieces of equipment are, of course, only a few of a large number in constant use. In surveying the over-all picture, to give credit to any one person or group for the building design and equipment would contravene our objective at the Hospital and Rehabilitation Centre—to function as a team. In this way only are we able to improve our ability to give the highest value in rehabilitation to the persons we treat.—*Geo. L. Pollard, remedial gymnast.*



Iron shoes help these patients to strengthen muscles

Patients cheerfully wind away the miles on these "bikes"

This jig saw is worked by a treadle to toughen legs

Occupational therapy department

THE occupational therapy department has a treatment staff of 23—one supervisor, two assistant supervisors, 19 staff therapists and one craft worker. Two typists do the clerical work required for the department.

There are eight sections in the occupational therapy departments.

The hospital section. A preparation and storage room is located on the first floor of the hospital area. In charge here is a craft worker who prepares crafts which are easily done by the bed-patients. The craft worker has a blanket prescription for these patients unless otherwise directed by the medical officer through the occupational therapists who are working with him.

O.T. 1 This section is used for the treatment of ambulant patients from the hospital as well as for upper and lower extremity amputees. Once a week the medical officer makes rounds with the treatment staff and referrals to O.T. are made at this time. The program is usually light because these patients may still be in casts, in wheelchairs, on crutches or on canes.

The pre-prosthetic treatment and the prosthetic training of the upper extremity amputee are both the responsibility of the occupational therapist. The therapist records and reports her findings to the amputee conference which is held weekly. The lower extremity amputees are given specific treatment by the occupational therapist but their training is the responsibility of the physical therapist and remedial gymnast.

O.T. 2-5 These four identical sections are used for the treatment of all non-hospital patients. Two occupational therapists work with the same medical officer and have weekly meetings with him and his physical therapist to discuss the patients' progress. The medical officer prescribes the type of activity plus any restrictions. From this the therapist, with the patient, arranges his program.

The activities here are bench and construction carpentry, remedial games, copper work, rug making and weaving, as well as the heavier activities of lifting, sawing, using wheelbarrows, and climbing ramps, ladders and stairs. As soon as possible the therapist introduces activities which are components of the patient's former employment. The therapist writes progress notes on her patients every two weeks. A copy is sent to the medical officer and the vocational rehabilitation officer.

O.T. 6 This section is used by all medical officers for patients on a heavy program, a work test or a physical appraisal. The heavy work consists mainly of the components of the patient's former job —taking his injury into consideration, of course. A work test is prescribed by the patient's medical officer when he feels the patient's physical capacity warrants discharge but is uncertain whether or not the patient can meet the environmental conditions and physical demands of his job on a weekly basis. A physical appraisal is an evaluation of a patient's work tolerance and is prescribed by the medical officer when a patient is not able to return to his former job, either because of a temporary or a permanent disability, or because the job no longer exists. The purpose of the physical appraisal is to determine the patient's work level so that he may be assisted or directed to employment within his physical capacity. A copy of all reports is sent to the medical officer and vocational rehabilitation officer.

O.T. 7 This is the occupational therapy section of the medical rehabilitation unit. Here the occupational therapist works very closely with the medical officer, the physical therapist and the vocational rehabilitation officer to appraise the "total" patient. This appraisal is done using various activities which are graduated from light to very heavy.

The occupational therapy department has a large outdoor area adjacent to the department. This cemented area is used by all sections for outdoor activities, mainly during the summer months. In another outdoor area, the department has facilities such as a small-sized box car, telephone and hydro poles, cords of wood, railway tracks and large cut trees. Most of this equipment has been donated by industries in the province who have been of great assistance to the department.

During the summer months, one therapist is in charge of the gardening. The department looks after a certain area of the hospital grounds and also has a small vegetable garden. All the plants and flowers are started in the greenhouse. The planting of seeds and the transplanting is carried out by a gardener with the assistance of patients who are on specific treatment.—*Joan Hillhouse, occupational therapy supervisor.*

Vocational rehabilitation

A DIVISION of the rehabilitation department at the Centre provides a vocational service, and in doing so forms an integral part of the total rehabilitation process. On the staff are a supervisor, a medical rehabilitation officer, four rehabilitation officers, one psychologist, one vocational counsellor, one vocational test examiner and a battery of secretaries. The supervisor reports to and is directly responsible to the chief rehabilitation officer of The Workmen's Compensation Board.

One rehabilitation officer is assigned to the patient load of two doctors. Every patient is interviewed as soon as possible after the doctor has completed his ad-

mission report—this report providing the basic guide for classifying a patient according to his particular need for vocational rehabilitation service. Thus, the patient who presents no serious social or emotional problems and whose medical prognosis indicates early return to unrestricted activity is given the least service; *i.e.*, only contact with the employer insuring re-instatement, or failing this, formal referral to the special placement division of the National Employment Service.

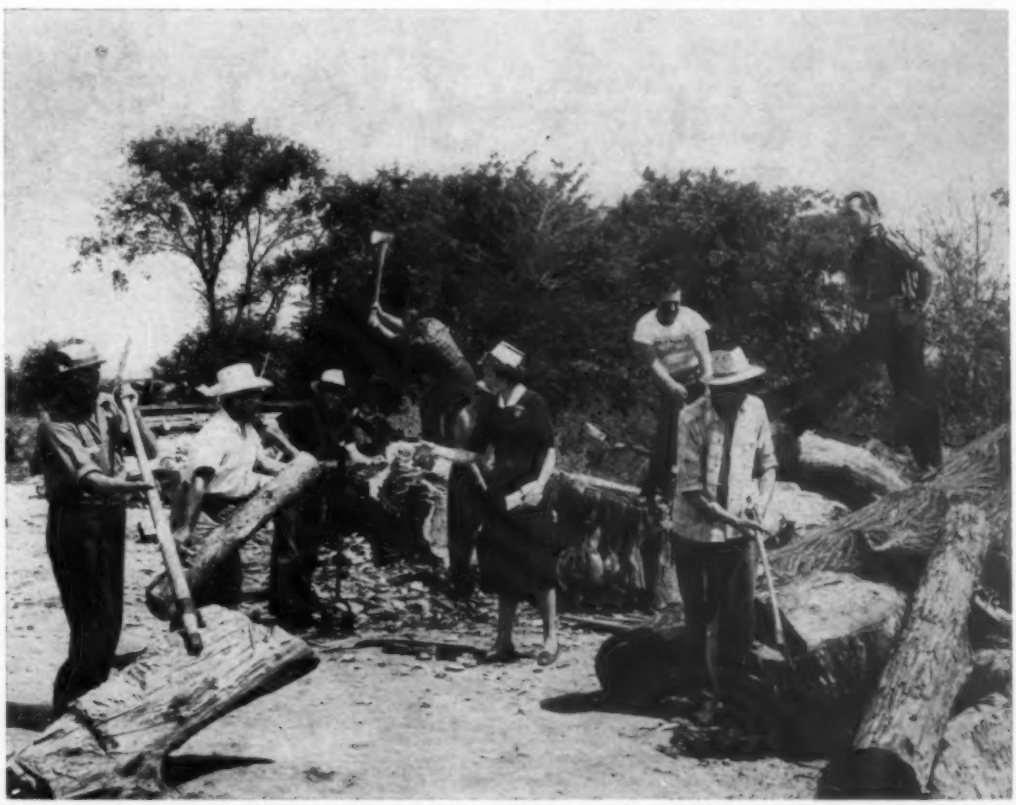
The patient who presents no serious social or emotional problems, but who requires temporary job modification will first undergo assessment to discover the extent of his temporary limitations. Secondly, the employer will be provided with an appraisal of the workman's ability to perform at a given level of tolerance. Suggestions may also be made as to his suitability for specific jobs when these are known. Then there is the patient who once again presents no serious personality problem, but who requires a permanent change in vocation. Such a patient will be given unlimited service, including, if necessary, formal vocational assessment, selective placement in employment with his pre-accident employer, or new employment. Vocational training may be provided when suitable placement is not practical without it.

When arrangements for a return to productive employment are not possible, or may be difficult without a personal contact with the employer or prospective employer, the services of a field rehabilitation officer may be called upon. The field rehabilitation officer draws on his knowledge of community resources, his knowledge of industry, and personal relations with industrial executives. Priority for field service is given to the more seriously handicapped patients.

Members of the field rehabilitation staff do not constitute an integral part of the Centre's organization. They are under the direction of a field supervisor who reports directly to the chief rehabilitation officer. The field officer does not come in contact with patients unless on a referral basis from one of the Centre's rehabilitation officers. "Referred" patients are formally registered with the department for permanent records and follow-up. A registered case is ultimately closed as "rehabilitated" or otherwise, and may be re-opened for further action when necessary. The Centre's rehabilitation officer continues to work with referred patients. He provides liaison between the Centre treatment staff and the field officer. It is the field officer who is responsible for the ultimate rehabilitation of a referred case.

The medical rehabilitation officer works with the medical rehabilitation unit team (described elsewhere). The patients he deals with are those who present social and emotional problems of sufficient severity to retard their return to productive employment. He is required to give an intensive social case-work service. He works with one doctor, carries a small case load and participates in the rehabilitation process on a continuing basis throughout the patient's stay at the Centre. Because of the nature of his work, his recourse to the services of a field rehabili-

The occupational therapist looks over her "lumber men"



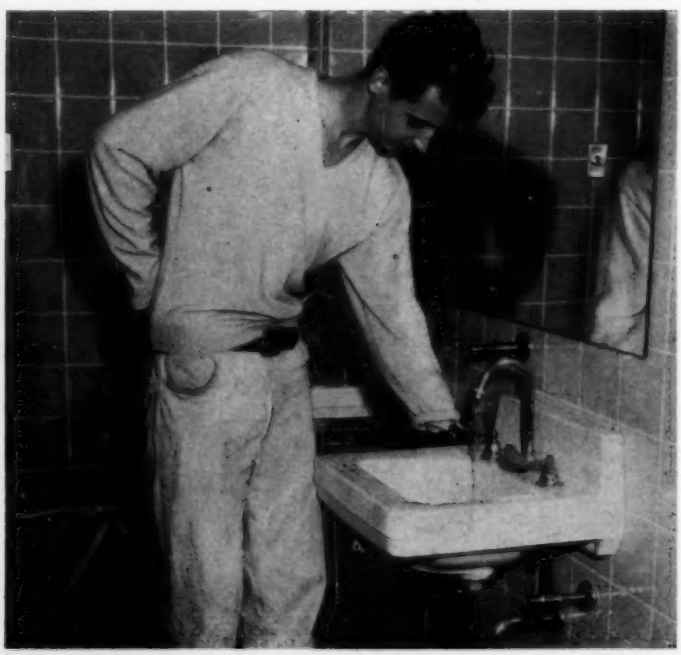
tation officer is more frequent than may be the case with the regular rehabilitation officer.

The psychologist is the senior person in the vocational rehabilitation counselling service (an integral part of the vocational rehabilitation division). He has as assistants a vocational counsellor and a vocational test examiner. Patients requiring formal vocational assessment (including psychometrics and aptitude testing) are referred to the counselling service by rehabilitation officers. Patients presenting serious personality problems in the treatment situation may be referred by the doctor for basic personality evaluation.

The supervisor is responsible for the over-all operation of the division including quality control and training. He is not directly involved in case-work, except in some very unusual circumstances.

The vocational rehabilitation division does not function independently of other services. As stated earlier, it is an integral part of an organization in which various services perform specialized but interdependent functions. The principle that successful rehabilitation can be accomplished only by a combined effort of all clinical services as well as of the community at large, is strictly adhered to. Rehabilitation officers are trained to work on the fundamental assumption that a physical or mental disability need not be an occupational handicap. Furthermore, they are trained to think of the person's working capacity not as simply the product of anatomical make-up, but rather as something that stems more particularly from native ability, personality, training, aptitude and determination. Thus, it follows that the approach to problems of vocational rehabilitation is on a personal rather than "disease entity" basis. The rehabilitation officer accepts the principle that the patient should be directed towards self help, independence, as well as adjustment to the functional limitations resulting from the disability. He also counsels the patient in the use and development of compensatory bodily mechanisms which would aid in the lessening of the handicap.

Statistically, about 80 per cent of the patients return to former employment, temporarily modified employment or to a new vocation at the time of discharge. The remainder come under the category of further treatment, field service follow-up, and referral to the special placement division of the National Employment Service. About 10 per cent to 15 per cent of the Centre's patients are referred for field service. Rarely is a patient discharged without any action having been taken by the rehabilitation officer.—*J. M. Parkin, rehabilitation supervisor.*



It's no trouble for amputees to use basins in washrooms which have special faucets to turn water on and off at a slight touch

The amputee program

CLAIMANTS who suffer amputations from mid-tarsal level and from the hand upwards are considered major amputees and are dealt with at the Centre in a special way. They are admitted to the hospital section under the care of one medical officer and a specialist team — a nurse, physical therapist, occupational therapist, remedial gymnast, and vocational rehabilitation officer.

In the upper limb cases, the accent is on occupational therapy. The lower limb cases receive the special care of the physical therapist and remedial gymnast. However, all three are concerned with each case. There are also two plaster technicians who have become experts in making all types of walking pylons, and upper extremity provisional training prostheses, thus contributing to the more rapid progress of the patients. This team of specialists accepts as a first principle that early fitting of a prosthesis raises the morale of the patient.

Two special conferences have been established to handle this group of patients:

The amputee conference is the operating conference and is concerned with (a) directing the rehabilitation of the amputee as to diagnosis, pre-prosthetic program and vocational rehabilitation; (b) prescribing the prosthesis in standard, uncomplicated cases; (c) supervising the functional training program of the amputee after receipt of prosthesis and his progress until ready for discharge or referral to the amputee consultant conference; (d) directing transfers from the hospital section to the clinic dormitory; and (e) authorizing discharges in uncomplicated cases and in other cases if directed by the amputee consultant conference.

The amputee consultant conference (a) acts as a consultant body to the amputee conference and directs the handling of problems presented by non-standard or complicated cases, including double and out-patient amputees; (b) advises on the development of the amputee program; (c) advises and assists in educational programs for the professional staff of the Centre on the subject of amputees; and (d) encourages the attendance as ob-

servers of members of the treatment and vocational rehabilitation staff of the Centre, members of the medical profession, and professional visitors to the Centre.

In the amputee conference are the members of the amputee team (described above). It is chaired by one of the treatment supervisors and meets each Thursday afternoon.

The amputee consultant conference consists of a medical chairman, a surgical consultant in amputees, the physical and occupational therapists and the remedial gymnast attending the case, as well as upper and lower limb prosthetists and representatives of the vocational rehabilitation staff. This conference convenes on Tuesday mornings as required.

Once the patient is discharged from the Centre, he becomes the responsibility of the head office medical department which may refer him back to the amputee consultant conference as an out-patient in the event of recurring trouble, either medical or prosthetic.

Prostheses are made by the prosthetic services staff at Sunnybrook Hospital D.V.A., and it is by arrangement with the director of these services that the two prosthetists attend the amputee consultant conference. The success of the amputee program is largely due to the excellent liaison and co-operation which exists between the Centre and the Sunnybrook staff.

A vocational rehabilitation counselling service, staffed by two qualified psychologists, is maintained at the Centre and is available to the amputee team for the vocational and personality assessment of the amputee patient.

A vocational rehabilitation officer, himself a below-elbow amputee, has been assigned to assist amputee claimants residing in Metropolitan Toronto. This officer is also a member of the amputee consultant conference and it is he who presents the out-patients to it.

This co-ordinated pattern of management permits a fair evaluation of the patient and helps avoid the problems of disorganized care.

Special follow-up studies are carried out under the direction of the rehabilitation and treatment services committee of the Board to learn the problems of the amputee and to improve the service to this group of patients.

The co-operation of the medical profession in the province is sought in obtaining the admission of amputees to this Centre in all uncomplicated cases as soon as wounds are healed.—*H. N. Martyn, secretary to standing committees.*

Wheelchair patients are served at the table in the bright cafeteria

Food Service

MECHANIZED meals is the outstanding feature of the catering system in use at the Centre. Because of its functional contemporary design, the Centre's 14 buildings cover some 15 acres. Bed patients in the hospital section are a good eight to ten brisk-walking-minutes from the kitchens. To avoid the age-old gripe about "hot" cold dishes and "cold" hot dishes, the W.C.B. has wisely adopted the new mobile meal approach to solve this problem. And solve it they have; for this compact mobile food service unit is designed with both heated and refrigerated compartments. In each "oven" drawer two patients' servings can be held—entree, soup, vegetable dish, and coffee cup. The made-up trays are neatly stacked in the shelved refrigerated section. Beverage containers, each with a two-gallon capacity, are mounted on the top of the unit. In this way food at the temperature it should be can be transported to the wards.

The Centre, operating since last July, and officially opened in October, was built to replace the temporary type of buildings in use at Malton since 1947. Catering facilities there were installed by the R.C.A.F. in 1940. Hence, they were obsolete throughout the ten years that the Centre operated at Malton. The new Centre's kitchen and catering facilities were designed to overcome all the shortcomings and to incorporate other design features gained from experience and study of other installations.

The Centre at Downsview treats 500 resident patients at all times. They hail from the length and breadth of Ontario and their pre-injury fare is as varied as the industries they represent. However, because of the treatment activity engaged in during the day, they all have one thing in common. There is little difference in the quantity of food they require compared with the amount consumed prior to their accidents. This is a result of the treatment program which is one of activity.

Of the 1,575 patient meals prepared every day, an average of 150 are special diets. These include low calorie, reducing, low fat, diabetes and bland diets. The patients' cafeteria seats 500 and is approximately one-quarter of a mile from the treatment area. The staff cafeteria holds 200. A vary-

Food Service

sponsored by the

Canadian Dietetic Association

Everything at hand — trays are assembled neatly and efficiently, ready to go to the wards

ing number of patients who take their meals in the cafeteria require table service. The reason for this stems from the Centre's policy of encouraging patients using crutches, wheelchairs and canes to get from their quarters to the cafeteria under their own power.

The Workmen's Compensation Board Hospital and Rehabilitation Centre's catering is provided by Canadian Food Products Sales Limited, Industrial Division. Included in the catering staff are: chief dietitian, assistant dietitian and two assistant managers. There are 38 staff members employed in the preparation and service of food, including cooks, baker, counter girls and kitchen porters.

This company also operates a canteen for the convenience of the patients, dispensing cigarettes, chocolates, sandwiches, and coffee. Cigarette and hot and cold drink dispensers are posted in the clinic area for patients to use during their treatment "break" periods.

The pop-up system of storing dishes is used in the serving areas of the kitchen and cafeterias. Portable stack sinks are employed. Waste is removed to a refrigerated area on noiseless, rubber-tired conveyors. The dishwasher is the two-tank, rackless conveyor type. Pre-rinsing is done in the stacking area. The dishwasher's special feature is a nylon injection moulded conveyor which affords no contact with metal to chip or mark chinaware.

The conveyor type of bread toaster, featuring easy and convenient loading, is used at the Centre. Stainless steel is used wherever possible in the kitchen and on the counters. The walls are done in easily-maintained glazed tile which also affords maximum brightness. The ceilings are high and the lighting of a kind to give maximum benefit. Five fume hoods keep the air fresh.

Specializing in a high protein diet, the Centre's meats, both fresh and frozen, are supplied from the Canadian Food Products' commissary. Portion control is practised at the Centre although there is no limit on the number of "seconds" patients may have. They are required to return to the serving area for these.

It has been said that an army travels on its stomach. Because of the unusual treatment approach at The Workmen's Compensation Board Hospital and Rehabilitation Centre and the continual stressing of the importance of activity, unlike most hospitals, W.C.B. patients usually do not experience a slackening off of appetite. Getting them back to work in the shortest possible time is the goal. They might be called the "working army" and an important part of their rehabilitation is good diet, and the resultant high morale. They might be said to "travel on their stomachs", too. — *Georgina Ruthven, P.Dt., Canadian Food Products Sales Ltd.*

Source of income

Our revenue comes from charging The Workmen's Compensation Board a per diem rate for each patient during his stay at the Centre. It may sound strange that the W.C.B. Hospital and Rehabilitation Centre should charge The Workmen's Compensation Board when the Centre is part of the Board's operation. However, for billing purposes the Board regards its Centre in the same light as it

Hot foods are hot and cold foods cold in this compact mobile food service unit.

does any other hospital in Ontario.

A per diem rate is established to cover all operational expenses including the salaries of about 300 staff members. The staff consists of various administrative, technical, vocational rehabilitation, clerical, housekeeping and maintenance personnel. All doctors are on staff so that not only the operational expenses but also the cost of medical treatment is included in the per diem rate. Part of the daily rate covers the capital expenditure for financing the construction of the new Centre and purchase of the necessary equipment and furniture.

The funds to pay for the land, buildings and equipment were, in effect, borrowed from the reserve funds of the Board. The Centre then became a capital asset in the form of buildings and property rather than securities. The portion of the per diem rate covering this expenditure will pay back to the Board's reserves, over a period of time, the amount borrowed to build and equip the Centre.

Since The Workmen's Compensation Act and Board are financed by funds collected from the employers of Ontario who are under the Act, not one cent of public funds or taxpayers' money was used in the construction or is used in the operation of the Centre.

Occupational Therapy Supplies

In the occupational therapy department, heavy expense is incurred in the provision of material for therapy projects for the close to 4,000 patients who pass through our doors each year. This item alone accounts for $18,000 a year. The situation is met by allowing the patient to take home the article which he has made. He is charged the cost of material only. Of course, some patients do not want to take these objects with them, and so each year the department holds a sale, both at the Centre and the head office. The Board's staff then has an opportunity to purchase items at a reasonable price. As a result, we recoup a considerable portion of the money spent for the materials involved in occupational therapy projects.

Many of our operating expenses are the same as those of general hospitals. At the same time, we have some unusual expenses that are peculiar to our operation. Modern accounting methods and business office techniques are employed to record all financial transactions and maintain proper accounts.—*Wm. R. Kerr, administrator.*

Administrative policies

BRICKS and steel do not make a successful rehabilitation centre. Adequate space, facilities and equipment are necessary but, over and above the physical assets, it is the employees who make a centre outstanding. The difference between a mediocre and a really successful organization depends on all the people concerned. We are fortunate indeed. We have a staff, both professional and non-professional, who have created an excellent reputation for the Centre. And now we have been provided with modern buildings designed for our specific needs. Our staff can do an even better job as they help the disabled return to gainful employment.

In establishing staff-management policies we have tried to follow the fundamental principles of human relations. Management expects certain duties from employees; employees, in turn, expect management to carry out its responsibilities in their relationship.

One of our basic theses is to try to establish fair and practical policies. Our first responsibility is, of course, to the patient who is admitted to the hospital and rehabilitation centre for treatment. Our second responsibility is to our employees and to the Workmen's Compensation Board which is, in effect, our board of trustees. We must always keep in mind the best interests of these three groups.

How often have you heard an employee say that he doesn't know what is going on in his own organization? Today there is a trend toward improving communication. This has become one of our basic management policies. By using the various communication techniques, we attempt to keep our employees informed. Our excellent supervisory staff plays an important part in this system — one of the supervisor's responsibilities is to keep his department informed. We like our supervisors and staff to know in advance, if possible, of plans and changes that will affect them. They are consulted when such changes and plans are being developed, and thereby contribute a great deal to the Centre's efficiency.

Employees also like to be informed about their progress. A system of supervisor-employee interviews for both treatment and administrative personnel enables each employee to find out how he can improve. At the same time it gives the employee and the supervisor a chance to become better acquainted. Both can benefit from such an interview. If the employee is making satisfactory progress he is so informed. If not, he is encouraged to improve by a supervisor who is always willing to suggest ways of doing so. Our experience has shown that the staff appreciate frank, constructive comments. This is one way in which we improve personnel development which is so important to the employer and the hospital.

Rules and regulations, for both staff and patients, can sometimes be a real bugbear. Although we try to keep such rules to a minimum, the ones we do have are strictly enforced for all personnel. Personnel policies apply equally to the professional, treatment, and non-treatment staff. The administration is, we think, fair but firm. Our employees are kept well informed, and they know where they are going.

The last management policy is extremely important and involves all staff members. We try to create a pleasant and friendly atmosphere, so that everyone will look forward to coming to work each morning. No management edict or declaration can, in itself, accomplish this objective. It requires the co-operation and efforts of supervisors and staff members alike working together in a friendly, understanding and businesslike manner. Then there will be a pleasant work atmosphere. The plaque in the main lobby says in part, "Today's adversity can be tomorrow's triumph". It is the day-to-day activities of the staff that help make this come true for the many seriously injured workmen who are treated here. With a combination of the "big three"—staff dedication, good management policies and modern buildings and facilities—we hope to develop even more our skills and techniques in the field of rehabilitation.—*Wm. R. Kerr, administrator.*

Community relations

MORE than one new "industry" has been doomed to a history of poor public relations simply by not informing its public of its function before the public formed its own, often erroneous, impression. With this thought clearly in mind, the Board's public service division began a program of public relations with the small community

(continued on page 62)

(L. to r.) Mrs. E. McKellar, E. M. Crowe Memorial Hospital, Eriksdale; H. B. Devine, Portage la Prairie; Ruth Lang, Selkirk General Hospital, Selkirk; G. B. Rosenfeld, Victoria General Hospital, Winnipeg; and Mrs. E. Simms, Swan River Valley Hospital, Swan River.

Manitoba Housekeeping Institute

sponsored by
the Canadian Hospital Association
and
Associated Hospitals of Manitoba
January 19-23

L. to r. are Sister Justina, Arborg; Sister Melania, Gimli; Mrs. M. Stinton, Manitoba Sanatorium, Ninette; and Mrs. M. Didur, Portage la Prairie.

Forty-one attended the five-day institute

Thirty-three people turned out at the Regina General Hospital

Saskatchewan Housekeeping Institute

also under the sponsorship of the national and provincial associations

Eleanor Mountenay, Regina Geriatric Centre, Regina; Jeanne Nolin, Notre Dame Hospital, North Battleford; Lillian McLeod, The Children's Hospital, Winnipeg; and Sister Janet, St. Joseph's General Hospital, Estevan.

held from
January 26-30, 1959
in
Regina

Agnes Chapman, St. Paul's Hospital, Saskatoon; J. Gombkoto, Winnipeg General Hospital, Winnipeg; Catherine Rogers, Saskatoon City Hospital, Saskatoon; and Mrs. V. E. McArter, Regina General Hospital, Regina.

Standing: Robert d'Esterre, personnel superintendent, Canadian Industries Limited, Edmonton; C. J. A. Sloan, regional co-ordinator, S. W. Regional Hospital Council; and William Dodge, executive vice-president, Canadian Labour Congress, Ottawa.

Seated: (l. to r.) are N. R. Werezak, secretary manager, Eston Union Hospital, Eston; D. Z. Daniels, chairman of the board, Canora Union Hospital, Canora; and M. F. Kushnir, superintendent of the Canora Union Hospital.

Saskatchewan Labour Relations Institute

sponsored jointly by the
Canadian Hospital Association and
the Saskatchewan Hospital Association

Held at the Civic Health Centre in Regina, January 28-30, 1959, the institute was attended by 45 persons from the three prairie provinces, including trustees, administrators and personnel directors of the hospitals.

Sister Mary Esther, administrator of St. Joseph's General Hospital, Estevan; Sister Margaret Marie, administrator of Holy Family Hospital, Prince Albert; and Sister Francis de Sales, St. Michael's General Hospital, Lethbridge.

Panel on labour relations: Peter Driedger, National Union of Public Employees; H. L. McLennan, secretary manager, Saskatchewan Employers' Association, Regina; Don MacMillan, trustee, Yorkton General Hospital; Philip Rickard, executive director, Saskatchewan Hospital Association, Regina; William O'Neill, business manager, St. Paul's Hospital, Saskatoon; and William Dodge, executive vice-president, Canadian Labour Congress, Ottawa.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Community Relations
W.C.B. Hospital
(concluded from page 57)

of Downsview, Ontario, three years ago; in fact, as soon as it was decided that the new Hospital and Rehabilitation Centre would be built there.

We knew of the dangers of the public's not being aware of the Centre's true purpose and function. The community might form the impression that the new Centre would house mentally deficient patients —and would be unduly alarmed over all the possible attendant problems. Members of the community would very likely have little, if any, conception of the meaning of physical medicine. To say the least, they would wonder at both the unusual design of the Centre and about some of the strange looking treatment equipment that they would see installed. Toward the establishment of a better understanding of the work being done there and to foster community co-operation the Board embarked on an information program. There were, of course, many other reasons why it was considered important to inform the community.

The next big job was to determine how best to do this. As soon as the public service division of the W.C.B. was made aware of the over-all policy of the Centre, the editors of all the local community weekly newspapers were given the story. Photographs were provided and every other sort of assistance was given to them to smooth the preparation of their articles. The same offers were extended to all other Ontario newspapers. Thus readers throughout Ontario, and in the Downsview area specifically, were enlightened with some pertinent facts about the Centre's finance, operation, design, treatment approach and many other things. The striking effect of this initial project was to establish in the minds of the community the proper attitude toward the patients, the treatment staff and the administrative policies of the Workmen's Compensation Board. Also it served to acquaint them with the extent of the humanitarianism so abundantly evident in the Workmen's Compensation Act, and which motivates the staff in its dealings with the injured men.

Shortly after this local officials from the Downsview area, including the reeve, municipal officers, representatives of industry and others, were invited to lunch at the Board's head office. There they were given an opportunity to ask questions on how the Centre might affect their community. It was evident then, even at that early stage, that their co-operation would be forthcoming.

The turning of the first sod was the next event. It was widely covered in pictures and in articles in many provincial newspapers. Also several Downsview dignitaries attended to observe the ceremony. During the intervening months between the sod turning and the cornerstone laying, progress reports were made to all media of communication — they were extensively used. The cornerstone ceremony was attended by members of the community as well as by representatives of management, labour and the medical profession

from many parts of Ontario. Newspapers, radio and television all covered this ceremony, and many articles appeared in the periodical press.

One interesting development that speaks well for the success of the community relations program involved a smoky incinerator stack. One day we received a call from a member of the community. He was calm, cool and collected and almost apologetically claimed that the soot from our stack was leaving a film of dirt over everyone's car as well as making a mess of the community's washing. He said that he had been elected to bring us the sad news, and that they could put up with the sooty cars but had to draw the line at the laundry being soiled. That night there was no soot and never has been since.

Before the official opening day, but while the Centre was in operation, press tours were arranged for the daily, weekly, periodical, radio, and television people. They toured the Centre and were given a press kit complete with photographs and a fact sheet. A question and answer period was held after the tour.

Official opening day received international coverage. It followed two "community nights" when a big turnout of local citizenry viewed the Centre along with head office personnel from the Workmen's Compensation Board.

The community relations program is still being carried on to maintain the friendly relations which have been built up over the past few years. And you can be certain of one thing: it is the only way to make sure that many unfortunate happenings are anticipated and prevented or corrected. — *Wm. G. Dulmage, assistant director, public service division.* ■

Health-Conscious People

People are far more health-conscious than they used to be. Thirty years ago, for example, a much lower proportion of the population consulted a doctor during a given year, and the average number of visits per person was only half what it is today.

Moreover, the use of physician visits for health examinations, immunizations, and other preventive services has increased. Not so long ago consulting a doctor was often considered a sign of weakness; now it is recognized as common sense in times of health as well as sickness.

Despite this increased consciousness of the public at large, there are people who ignore the importance of prompt, regular medical attention. But the number of holdouts is declining sharply. It will decline further as the benefits of preventive medicine become better understood by everyone. — *Health Information Foundation.*

Nuclear Reactor— A Medical Milestone

A 1,000-kilowatt nuclear reactor is a major part in the new medical research centre at Brookhaven National Laboratory, Upton, L.I., N.Y. Dedicated in December of last year, the centre gleams with the tools and knowledge born of the atomic age. Besides the reactor, it has a main laboratory building for studies on the medical application of atomic energy, a hospital service area and four 12-bed nursing units.

The powerful beams from this nuclear reactor will be used for cancer therapy and for treatment of some types of brain tumors.— *A.M.A. News.*

The Canadian Red Cross and the American Red Cross have a mutual agreement to supply free blood to tourists who may require blood transfusions while visiting in their neighbouring nation.

administrative and legal aspects of

Hospital Consent Forms

W. A. J. Farndale, B.Com., F.H.A.,
London, England.

Part II

Right to refuse operation or treatment

A patient in hospital has a right to refuse an operation under any circumstances and cannot be forced to sign a consent form. Indeed, to force him to sign a consent form would result in its being of no legal value.

There are various grounds on which a patient may refuse to give consent to an operation—for psychological reasons, including fear or ignorance, or on religious grounds. Fear of a serious operation is understandable and it may take a little time for relatives or hospital staff to convince such a patient of the need and desirability for an operation. Economic reasons may in the past have prevented some patients from giving their consent, although beggars have been known to refuse an operation for deformities because their deformities were a profit to them. Then there is the occasional patient who persistently and on purpose renders himself unfit for work by refusal to have an operation which will cure him; sometimes such a patient may have a financial interest in retaining his disability. Another reason for refusal has been to avoid military or national service.

It has been suggested that in extreme cases of wilful neglect or refusal to agree to an operation, a hospital should be given power to over-ride unreasonable personal objections, provided the decision to operate was shared among several members of the medical staff in what might be termed a "pre-operative medical conference". It is doubted, however, whether this would be acceptable to hospitals and medical staff, and it would not be approved by the general public, who would consider it an undue limitation of their freedom.

It is interesting that in one part of communist China hospitals have now abandoned the system of a patient's signing the operational permit (which they call "irrational") and instead have established a pre-operative conference system. This is contrary to our democratic principles which recognize the freedom and liberty of citizens to refuse an operation.

The pre-operative medical conference is occasionally used either formally, especially before a leucotomy operation, or informally where a doctor obtains a second opinion from a colleague, though never at the expense of the consent form. Such consultations are an additional safeguard for the doctor and for the patient.

Christian Scientists

Those who have religious grounds for refusing consent to an operation or treatment may include Christian Scientists. If a Christian Scientist does decide voluntarily to enter a hospital, he will prefer to have as little medicine as possible and would not expect to be operated on without his express consent. If a Christian Scientist is admitted to hospital involuntarily through being rendered unconscious in an accident, he may wish, on regaining consciousness, to be discharged or transferred to a Christian Science Nursing House (nursing home). In this event the patient or relatives are usually prepared to sign a statement relieving the hospital authority of any further responsibility.

Several authors have criticized Christian Scientists for their attitude towards medical treatment, including Dr. Leslie Weatherhead in *Psychology, Religion and Healing* (Hodder & Stoughton), the Rt. Hon. H. A. L. Fisher in *Our New Religion*, and Horton Davies in *Christian Deviations* (S. C. M. Press). A more sympathetic view is taken by Norman Beasley in *The Cross and the Crown* (Allen & Unwin). Taylor's *Medical Jurisprudence* (11th Edition, J & A Churchill Ltd., 1957) points out that so far as an individual is concerned it is his own affair whether he obtains treatment or not, but the case is otherwise when a person responsible for the health of another refuses to obtain medical treatment.

Under the Children and Young Persons Act 1933, in the United Kingdom, parents may be liable to a criminal charge if they fail to provide adequate medical aid for their children, and refusal on the part of a parent to give consent to medical treatment might be deemed by the law to be cruelty or neglect. In fairness to Christian Scientists they do, however, advise parents of children to call in a doctor when a reasonably careful parent who is not a Christian Scientist would do so.

A Christian Scientist who becomes ill asks for help from a Christian Science practitioner, the basis of whose treatment is reliance on the power of prayer to heal. This being so, he would consider his freedom to practise his religion hampered if he were compelled to submit to medical treatment. Christian Science treatment is based on the belief that "God created man in His own image perfect as Himself, wholly spiritual, and incapable of sickness or sin". It asserts that "the conception of man as sick and sinful is erroneous—Christian Science treatment is prayer—an affirmation of spiritual truth that awakens man to the perfection of God's spiritual creation".

Christian Scientists state they respect sincerely the unselfish healing efforts of doctors, surgeons, psychiatrists and others, but their experience shows that Christian Science and medical treatment do not mix. They do, however, employ nurses specially trained in Christian Science to take care of the physical needs of patients while they are receiving Christian Science treatment.

The hospital attitude towards adult patients who may be Chris-

(continued on page 98)

Mr. Farndale is deputy house governor and deputy secretary to the board of governors of The Bethlem Royal Hospital and the Maudsley Hospital (a post-graduate teaching hospital) in London, England. He is also a barrister-at-law of the Middle Temple.

p. 65/66 adv.

You Can Do It

— the accountant's job under Ontario's hospital insurance plan

E. P. McGavin, C.A.,
Toronto, Ont.

WE are now at a point where hospital figures are becoming more useful and clear. Figures are the language of business and yours is a vocation of providing clear language.*

The Commission's Philosophy

Have you understood the commission's philosophy on how the hospital plan will operate? This has been discussed in speeches and articles, but the key rests in one sentence — control rests with the hospitals. It will continue to be the responsibility of hospital boards, administrators, accountants and staff to operate the hospitals in 1959 as they have done in the past. This has to be done within the framework of two insurance Acts, the two sets of regulations, and the commission's policies. You are free to make the decisions and to operate the hospital, but you are accountable for the services you provide and the costs you incur. You should study this material and know the meaning of these rules and regulations.

May I add that the general public and the taxpayers of Canada will probably judge the hospital operation in Ontario as successful if we provide the best patient care at the lowest cost under the hospital insurance plan. That is a fundamental rule which the management of every organization—service or commercial—tries to follow.

All of us in the next few years will have to see that we don't spend money we don't have on things we don't need. That, of course, is not the manner in which prudent people manage their affairs.

Cost Control Through Budgets

You are, in large part, the controllers of hospitals in Ontario. Control of expenditures under the hospital insurance plan will have to be just as efficient in your hospital in 1959 as it was in the past.

What are your responsibilities to the plan? Many of the duties are not new to you. A number may already be in operation in your hospital, but there is nothing wrong in repeating points with which we are familiar. Sometimes we see them in a new light. Some may need adjusting — to be applied to your case.

Budgeting

In every hospital which has had good budgeting in the past — in fact, in any business organization which has it—there has been teamwork. One of the rules of good budgeting is teamwork within the hospital groups.

When you decentralize your responsibility into departments, put under department heads, you get a better budget throughout the hospital. That is why, in the explanatory notes to the 1959 budget it was stated: "the administrator of each hospital should arrange for departmental supervisors to take an active part in preparing the budget so that it will be as accurate and realistic as possible". The people who do the spending are the supervisors. If you can develop in them a sense of responsibility and give them the authority which goes with this duty they will know they are on the team. They will be better employees and supervisors, and they will become more interested in helping to control.

Salaries and Numbers of Employees

At various institutes held recently it was stated clearly that the commission wants to leave control of salaries where it should be—with the people who run the hospitals, but you will have to be as diligent as if you were raising the money yourselves.

The number of hospital employees is an important point to remember. The commission expects that you will have standards by which to decide the number of staff required in each department. When regional representatives of the commission visited hospitals in 1958 this point was discussed quite frankly. But there is need for more clear-cut standards. This is a responsibility of the administrator and the head of each department should be a partner in the decision. It is a rule of good management that department heads should be responsible for their own operations, but accountable. They should know what duties have to be performed and be able to judge how many people they require for good care and efficient, business-like operation.

In some hospitals, standards have been carefully worked out by directors of nursing services, but we found that in some dietary and maintenance departments there were no standards. The administrator usually agreed, after discussion, that he depended on the supervisor, but felt that there was some overstaffing. The commission will develop standards but it has to be done gradually. We expect that you will have some manner of judging that the number of persons in each department is adequate, but not excessive.

Overhead Control

I once heard the vice-president of a large company say that overhead is largely people. This is a simple and correct definition of much of overhead cost. The vice-president also said that reducing overhead is often a matter of revaluing work programs in each department. He told of an organization which studied overhead by a new approach. They didn't try to cut or reduce costs: they tried to get rid of them entirely. This organization approached each department head and top management, saying "If this were a new business, what information would you need to run it?" Apparently, this was an effective approach because the organization was able to make a large annual saving. This was accomplished without new office machines being used, and a faster service was provided after the change.

** Mr. McGavin is comptroller of the Ontario Hospital Services Commission. He gave this address at the Accounting Section of the Ontario Hospital Association's convention, October, 1958.*

One of the chief causes of the continued rise in operating costs is the clerical and supervisory expense of processing paper work. Someone has said that if paper work is neglected for three years in most organizations, it will double. Paper work is increased by such things as the preparation of duplicate reports, and the filing of them in separate divisions. I suggest you can throw out much of the duplicate controls. Have you established "forms" control in your hospital? Review your present system before you take up mechanization and you may be able to improve it without any capital expenditure. For this type of improvement in your operating and clerical costs, you must have the enthusiastic backing of the administrator. The top executive — the administrator — must set the goals and measure the results by how many people come off the payroll. That is the only way to judge if office overhead has been made efficient.

Internal Checking

Look at your internal checking. Another reason staff is high in our accounting office is that we overwork internal checking. Outside auditors catch some errors, and we immediately set up an additional routine. Occasionally, it is a good thing to have a close critical look at internal checking.

Look around at any of the time-consuming jobs in the office and you may find that some of these could be reduced. For example, why do you have people check extensions and additions on *all* purchase invoices? You can check invoices over $100 for clerical errors, and spot check others. If you have a small office that won't save any people, but in larger offices this will save you many hours a month.

Accounting

Here are a few of the things which we expect will be carried out under the plan this year:

Departmentalization

Full departmentalization of all direct costs in the accounting records will be necessary in 1959 for hospitals with a rated bed capacity of 75 or more. The commission will expect the accounting records to show accurate expense distribution by department. That is not entirely new. Hospitals with less than 75 beds should charge expenses to departments, but drugs and medical and surgical supplies may be charged to one expense account. Salaries may also be charged to one account, but only if no distribution is possible.

It is now necessary to have the direct costs of organized out-patient clinics charged to separate expense accounts because these are not insured services. This means salaries and wages, medical and surgical, other supplies and drugs.

There is a further reason for stressing proper departmental expense accounts. As the plan develops over the next two or three years, certain inequalities in the arrangements may be revealed. It will provide sound information for proposing changes in the Act or regulations if you have costs which accurately reflect what is happening in the various department and cost centres.

For example, when studying the effect of 7 (3) (j) of the federal regulations, which is special services to out-patients, the commission summarized the figures on your 1955 annual financial returns and some errors and omissions were found. This is not good enough. We must have correct distributions in 1959.

Internal Checking

We expect that you will have adequate safeguards and internal check on receipts and disbursements. Monthly bank reconciliations are necessary in a well-run office. It is a surprise to find that this is not done in some hospitals.

Accounts Receivable

The balancing of the accounts receivable ledgers each month to the general ledger control or controls is done now in some hospitals. Most of you do *not* balance. In some hospitals, there are substantial differences which run into hundreds of dollars. This is one of the aspects which reveal good staffing and good organization, and the commission will require this of you. In others, if it comes close, it is held over until the next month, and at the year end the shortage is written off to operations. This has been discussed by the commission and they will insist on a proper, business-like monthly balancing. No year end write-offs will be accepted.

Collection

Your credit policies and bad debts will still be important even with 90 per cent of the Ontario residents insured. You will have non-insured people, semi-private patients and some non-resident patients. You may have to divorce your hospital from present collection routines and some of you will have to become tougher. You should also use a proper monthly overdue report. Talk to people at the Ontario Hospital Association who can explain good collection techniques. You can learn from them how others have met this problem. But let me warn you—there is no open door policy for all uninsured accounts to be accepted as bad debts. There will be a clear-cut line and if bad debts in your hospital go beyond what is reasonable after review of the facts, then they will be disallowed and you will stand the expense. This will depend on whether or not you have done absolutely all that can reasonably be expected.

Inventories

To have accurate costs every month for the commission and your board, accounting routines should be changed so that purchase of drugs, dietary supplies, medical and surgical supplies, and larger maintenance items are charged to inventory accounts. Requisitions should be made when these materials are issued. The requisitions would show the department in which they were used, and would be costed at the month end.

Stock rooms in enclosed areas are essential for stock control. However, in hospitals with less than 75 beds, if purchases in a month equal one month's requirements, we suggest purchases be charged direct to the expense accounts.

Expenditures

The commission expects you, as accountants, to make a correct distinction between capital and revenue expenditures. This is a basic accounting concept. Most of you know the difference, but let me restate its meaning. Under sound accounting principles, you do not charge to operating expense, new capital equipment or betterments, or equipment replacements. On the other hand, repairs and maintenance costs, which merely restore normal operating efficiency, are not charged to capital account. This distinction will be required in your accounting records.

Year-end Physical Inventories

Regional representatives have formed the opinion from discussions and inquiries that in many hospitals year-end physical inventories of food stuffs, drugs, medical and surgical supplies have not been as carefully taken as might have

(continued on page 108)

They Come and They Go

– and this costs money

R. Vadeboncoeur,
Winnipeg, Man.

WE ARE entering a new era in the history of health services. Manitoba has now joined its Western neighbours in a government-backed hospital services plan. One result of this transition has been the changes in financing hospital care, and these changes allow us to make a complete re-evaluation of our hospital management problems. Formerly, the finding of new and greater sources of revenue to finance patient care under rising costs and improved and extended services constituted the basic problem for hospital administrators. The existing plan has relieved us greatly and in so doing has permitted us to transfer emphasis from money problems to those having to do with the efficient use of facilities and personnel. It is of these latter that I would like to speak.

Let us consider our personnel turnover problem, and discuss means of identifying and correcting this—our most obvious and detrimental manifestation of personnel unrest and discontent.

There is a sense of urgency, born of an awareness that the savings or costs resulting from our success or failure in dealing with these problems will inevitably be of increasing interest and concern to the administrators under government hospital services plans. The continuation of our management prerogative in hospitals may well depend on our success in independently solving these and similar problems which contribute so much to hospital costs and our efficiency.

Turnover

Turnover, which you well recognize as the ratio of employee separations to total staff, was revealed by one comprehensive survey made in 1957 in hospitals of the United States and Canada to average 63.6 per cent per year. Hospitals of under 50 beds and those in farm and ranch areas averaged more favourably—with statistics ranging from 34 to 43 per cent. The 50 to 99-bed institutions, and all hospitals in industrial areas reported above-average turnover—83 to 95 per cent. When one stops to consider that the replacement of one departing employee may mean a recruitment effort (including advertising costs), training time given by several persons, new record-keeping, physical examinations, breakage and time less because of inexperience, and the cost of overtime required from regular workers to compensate for work not done by the new worker, one may begin to appreciate the high cost of turnover. It has been claimed that each separation costs a hospital a minimum of $300. This amount is reported to be many times greater with higher-income bracketed positions. Others place the cost of a separation at 500 times the hourly pay rate of the departing employee. If we use either of these bases, it remains a matter of simple arithmetic to translate the cost of our turnover into dollars and cents. In so doing, we might bear in mind that the cost arrived at will not include such harmful effects of turnover as poor public relations, impaired employee morale, and reduced quality of patient care.

Whether we accept the foregoing methods of evaluating turnover or not is incidental. It still remains a fact that, on the average, approximately two-thirds of our employees stay with us for less than one year. What then, we may ask ourselves, may we consider a normal personnel turnover? Although no one can answer this question with complete certainty, Norman D. Bailey, in his book, *Hospital Personnel Administration*, suggests that a turnover of more than 36 per cent is cause for concern.

If each hospital compares its personnel turnover with this suggested norm, the need, if available statistical data is any indication, to reduce turnover by approximately one-half will be revealed. To achieve such an improvement we must first probe into the basic causes of turnover. This is best done by establishing a continuing study of its causes kept current at least monthly.

Study of Causes

We find it helpful to separate terminations into four general divisions: avoidable, unavoidable, voluntary and involuntary. The number of causes by which turnover may be analyzed under these headings is a matter of preference. We believe the inclusion of the following causes is helpful in planning corrective measures: dislike of task, dislike of working conditions, wage discontent, furthering education, home responsibility, ill health or accident, end of agreed working period and discharge for incompetence or unreliability. The data so accumulated will be of best use if it is tabulated in a manner that will permit the identification of turnover causes by department and, where desired, even by job title.

The precise results of a personnel turnover analysis in our hospitals will vary, depending on the employment conditions of each hospital, but generally most of our voluntary turnover will be due to some disagreeable job factor such as rate of pay, hours of work, unpleasant working conditions, complexity of job, and lack of job satisfaction. For this reason we think that it is best to concentrate first on the correction of job-related turnover causes. Much of the solution therefore lies in the use of industry-proved job analysis and evaluation methods.

A job analysis program should not be started without much forethought about how comprehensive it is to be. You must also be ready to authorize the great amount of time that a complete and continued program will require. In some cases a partial program may be all that is warranted, particularly in the small hospitals, but a comprehensive plan should at least be considered in all cases.

When speaking of a comprehensive job analysis program, we visualize one in which the initial job analyses obtained are in sufficient detail to permit the subsequent installation of any of the following

(continued on page 116)

Mr. Vadeboncoeur is personnel director of the St. Boniface Hospital, Winnipeg, Man. From an address given at the Western Canada Institute, September, 1958.

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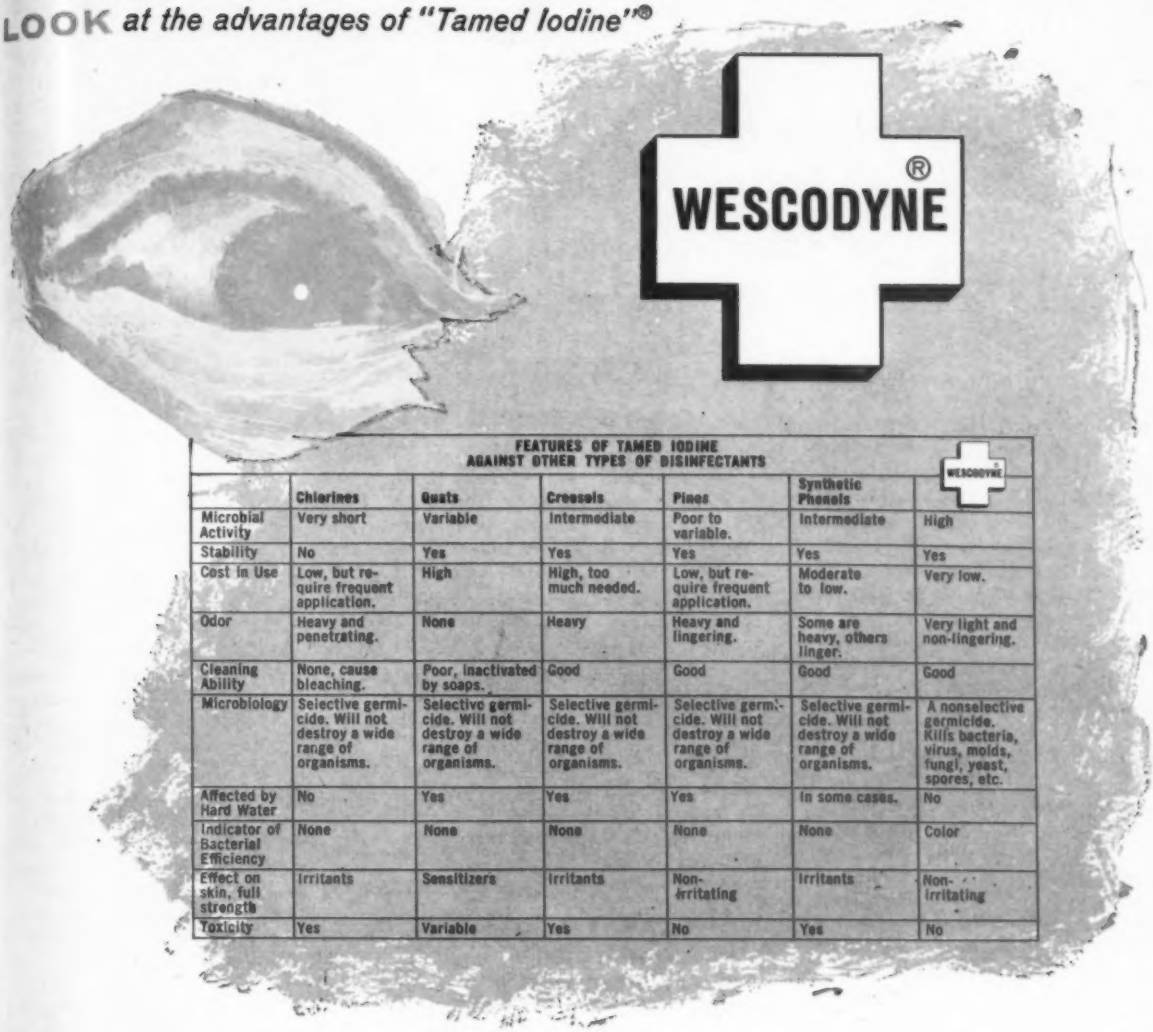

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Microbial Activity	Very short	Variable	Intermediate	Poor to variable.	Intermediate	High
Stability	No	Yes	Yes	Yes	Yes	Yes
Cost in Use	Low, but require frequent application.	High	High, too much needed.	Low, but require frequent application.	Moderate to low.	Very low.
Odor	Heavy and penetrating.	None	Heavy	Heavy and lingering.	Some are heavy, others linger.	Very light and non-lingering.
Cleaning Ability	None, cause bleaching.	Poor, inactivated by soaps.	Good	Good	Good	Good
Microbiology	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	Selective germicide. Will not destroy a wide range of organisms.	A nonselective germicide. Kills bacteria, virus, molds, fungi, yeast, spores, etc.
Affected by Hard Water	No	Yes	Yes	Yes	In some cases.	No
Indicator of Bacterial Efficiency	None	None	None	None	None	Color
Effect on skin, full strength	Irritants	Sensitizers	Irritants	Non-irritating	Irritants	Non-irritating
Toxicity	Yes	Variable	Yes	No	Yes	No

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WESCODYNE is the single germicide suitable for all hospital cleaning and disinfecting procedures. Its labor-saving detergent action removes soil and dust as germs are destroyed. This simplifies procedures, including those for the decontamination of surfaces that harbor "Staph" and other organisms.

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A Haven —

for unmarried mothers

Mrs. I. R. Sanderson,

London, Ont.

IN a lovely and secluded section of London, Ont., stands the Bethesda Salvation Army Hospital — for unmarried mothers. With its private grounds, it provides a quiet haven in the midst of the city. For this is a hospital with a dual purpose. Besides medical services, it must offer comfort and understanding to all the girls who come to its doors.

A very large step in this direction was taken when, in the spring of 1953, 40 interested, service-minded women united to form an auxiliary. Since that time, the auxiliary has accomplished a great deal. Now, thanks to their efforts in equipping a new clinic, the patients need not leave the hospital for pre- and post-natal care. Only complicated cases are taken by ambulance to a large hospital and returned by ambulance one or two days after delivery. The auxiliary has also remodelled and equipped the third floor of the hospital; it is now a dormitory which will accommodate eight more girls. A new library has been installed where girls may read or write letters. A former large sitting room has now become a lounge and visitors' room—here girls may talk quietly with visiting parents and friends. The ladies of the auxiliary have remodelled the recreation room, had a new floor put down in the dining room, remodelled the nursery, and installed a new stove and freezer. Small items, such as facial tissues and tooth brushes, are supplied to those who need them. And each year, the patients are treated to a Christmas party — complete with gifts and Santa Claus.

Thus the busy auxiliary members carry on, using their funds to modernize and equip the hospital, and their good spirits to brighten the atmosphere. Now there are three life members in this organization.

The hospital staff also contribute to the cheery, home-like atmosphere of this 25-bed hospital. They are as follows: superintendent, assistant superintendent, three qualified nurses, day supervisor of girls and their work, evening supervisor of girls and their work, bookkeeper, laundress and cook. The hospital is inspected regularly by representatives from the department of welfare.

There are two questions frequently asked about the hospital and its patients. The first is—"Do the unmarried mothers keep their babies or leave them for adoption through the Children's Aid Society?". In most cases, the infants are left for adoption. The mothers are often alone and financially unable to care for a child. And, for the child's own sake, it is often better that he or she know the love of a mother and a father.

The second question—"Do the mothers see their babies after they decide to leave them for adoption?"—can be answered with an emphatic "Yes!" This gives the girls a chance to decide, with no coercion whatsoever, whether or not they want to keep their children with them. The mother alone can face this problem — and it is our belief that she must be given time enough to make her decision. Both infant and mother leave the hospital from 10 to 14 days after the child's birth (if the health of both is satisfactory). There is then a six-weeks' period in which the mother can make her decision. Only then, if her decision is to have the child adopted, does she go into the courts to sign the legal document.

Life in the hospital is not much different from the home life of most expectant mothers. In the morning there is some light housework, followed by walks and handcrafts in the afternoon. Members of the staff instruct and help the patients in every way possible. From 3 p.m. to 4 p.m. is a rest period. Then the girls prepare supper. After the dishes are done, the evening is spent doing hand work, taking part in light games for exercise, reading, writing letters, watching television, singing songs, or resting. The girls may stay out one afternoon a week until 7 p.m.—this allows them to have supper out. Bedtime is 9 o'clock. Thus the girls experience a healthy combination of light exercise, entertainment and rest.

Chapel devotions are held for 15 minutes every morning and every Sunday evening, as well as every second Thursday evening. The girls attend these services if they wish—but they are not urged to do so. Since they are of all denominations, they are free to attend the church of their choice on Sundays.

Girls enter the hospital at the end of their seventh month of pregnancy—or earlier if they wish. They may come from all parts of Ontario, but before they enter this hospital in London they must make arrangements with their local Children's Aid Society for future care of the children. And after birth, the child is taken to the "home centre" Children's Aid Society — by the mother and her parents, by a Children's Aid representative, or by one of Bethesda's staff members.

The medical needs of the mothers (as well as their social and spiritual needs) are always considered. Two qualified doctors are on call at all times—and are at the hospital within minutes when they are needed. There is also a professor of obstetrics who comes with his students to conduct the clinic every week. The girls are well looked after indeed, yet money troubles never plague them. Each mother pays board ($1.00 a day), plus a hospital fee of $50—if she can. Most girls wait until they have a job, and then pay a small amount at a time. But, if this arrangement is also impossible, no demands are made by the hospital. For kindness and sympathy are what these girls need most—and that is what they get at Bethesda. ■

Mrs. Sanderson is the honorary president of the women's auxiliary to the Bethesda Salvation Army Hospital, London, Ont. From a paper presented at the Auxiliaries Section of the O.H.A. convention, October, 1958.

Solves Two Diet Problems . . .
the FAT and the FLAVOUR!

Fat-problem patients who, until now, have rebelled at advice to drink a fat-free instant powdered milk because of flavour, are no longer a problem with Mil-ko. Gone is the "chalky" taste so common with standard process drying. New-Flavour Instant Mil-ko tastes so good, it has many times fooled confirmed "whole milk" drinkers of all ages! Try it and see.

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p. 75/76 adv.

Flannel in the Mouth

Michael Hornyansky,

Ottawa, Ont.

THE kind of jargon I want to discuss may be more familiar to you under the name of officialese. It is the pompous, inflated language that says *at this time* when it means *now*, and *multilateral co-operation would be desirable in the light of events* when it means *everybody help*. I'd rather not call it officialese, because that suggests that only officials suffer from it, whereas it seems to me to be a disease infecting all sorts of people, and more of them every day. It comes naturally to every public figure, and to anyone trying to be a public figure. It is not really a form of communication at all—in fact it's well on the way to destroying communication entirely. It is a verbal smoke-screen, a method of saying very little and making it sound like a lot; and as such, it has its uses.

By jargon, then, I mean what the Americans call gobbledygook—the flannel-mouthed, pussy-footing bombast that passes for formal speech among politicians, civil servants, labour leaders, news commentators and even gentle souls like churchmen and teachers of English. There are other kinds of jargon. The word was first used to mean the noise that birds make; Chaucer, six centuries ago, described the magpie as "ful of jargoun". Afterwards it came to mean any jabbering or twittering — foreign languages, for instance, or the mysterious lingo of sailors, carpenters, doctors, and so on. Nowadays we still talk of legal jargon, or scientific jargon, meaning the special technical language that lawyers or scientists use. I don't see how anyone can reasonably object to jargon of this kind. To the layman it may still sound like jabbering or twittering—but it isn't meant for the layman; it is shop-talk. And as long as it stays inside the shop it is perfectly clear and direct. For example, take this: *the airbase in question has been phased out of operation and retired to caretaker status.* Now, that could be shop-talk. Spoken by one air officer to another, it conveys precise information about the personnel and equipment still left on the base. But addressed to the public in the form of a press release (as it actually was) it becomes gobbledygook: a pompous way of saying "the airbase is no longer in use".

The jargon I am objecting to has been defined as "the official language of the ruling classes". And in democratic countries, that means the official language of practically everyone. Not the language you speak off duty, to your family or friends; but the official, souped-up version you start using the moment you mount a platform or approach a microphone—the moment you want to impress somebody. Like a souped-up car or cocktail, it involves certain risks. But first, let's have a look at the recipe.

What makes jargon? The main ingredients are wool and pompousness. And how do we go about sounding woolly and pompous? Well, here are three useful ways: first, avoid active verbs; second, use plenty of circumlocution and padding; third, be careful to choose fuzzy words. A few examples, and you'll soon see how it is done.

The jargoneer would like to do without verbs altogether, and depend instead on thick, woolly clots of nouns, like *anxiety behaviour pattern, fun type program, moisture vapour transmission resistance.* But since he needs some verbs, he at least avoids simple strong ones like *help, happen* and *agree;* he prefers to *assist,* to *eventuate,* and to *associate himself with.* Or he draws on vague neutral process-verbs like *utilize, finalize, prioritize, hospitalize.* Whenever he can, he chooses the passive form rather than the active. He doesn't say *I think,* or *I tried;* he says *it is the general consensus,* and *the attempt was made.* You'll never catch him giving a direct order like *get to work.* For him, *it is imperative that action of a positive nature be implemented at the earliest possible date.*

Circumlocution is the use of several words where one will do; whereas padding is the use of several words where none is needed. Your jargoneer pads with formulas, like *with respect to your communication of the 14th inst., I have the honour to inform you . . .* or with adjectives and adverbs from which all meaning has been squeezed: like *serious, real, considerable, due* or *undue, relatively, respectively,* and so on. All these words can mean something—but not as jargon uses them. Take *active,* for instance, in phrases like *under active consideration;* nowadays *active* seems to mean simply that the speaker is not actually dead. The jargoneer never says *won't* or *can't*: he *is not in a position to, is not prepared to, cannot at this juncture undertake.* He is a great beater around bushes; he will never use *of, in, by, for, about,* when he can say *in the case of, on the part of, in relation to, as regards, in terms of.* He will avoid *before, after, more, behind;* and choose instead *prior to, subsequent to, upwards of, in back of.* He has an instinct for long abstract words with Latin or Greek roots—even if he's never learned a word of Greek or Latin.

You see the effect of all this. Churchill did not say in 1940, "The position in regard to France is extremely serious". He said, "*The news from France is very bad*". By the time that news is translated into *positions, situations, circumstances* and *factors,* all being *taken a very grave view of,* no news is bad; in fact no news is even new.

I said above that jargon comes naturally to anyone trying to sound important. This is not quite true. Everyone may have the instinct; but you need practice, and some talent as well. The result is that jargon tends to be esoteric and clubby. Like shop-talk, gobbledygook becomes the language of an in-group—even though it's a pretty big in-group. People who can't talk it feel and are treated like outcasts. Those who can, use their special language as a password or a fraternity grip. Flannel in the mouth becomes the sign of an elite.

But jargon is far from being a mere wilderness of flannel or wool. The jargoneer does try, in his own way, to ornament and beautify his language, though his mouth usually carries the kiss of death. One method, favoured by

(concluded on page 102)

Mr. Hornyansky is with the English Department of Carleton University, Ottawa, Ont. This talk was first broadcast over CBC Trans-Canada.

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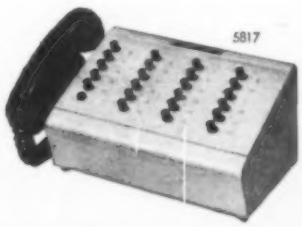

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Provincial Notes

Newfoundland

The new north and south wings of the St. John's General Hospital in St. John's are to be completed and ready for occupancy in June. The new wings will house a cancer clinic and Cobalt bomb. There will also be a laboratory and a suite of operating rooms in the addition.

After a meeting of the Central Newfoundland Hospital Committee with Newfoundland's premier and his cabinet ministers, it is believed that a hospital costing approximately $2,000,000 will be built in central Newfoundland. Construction will probably begin in the spring of next year.

After 14 months of successful operation, the Carbonear Red Cross Community Hospital was taken over by the six communities concerned to be run by a committee of interested, public-minded people. The Red Cross was to have run it for a full two years.

Prince Edward Island

A motion that immediate steps be taken to have the Stewart Memorial Health Centre at Tyne Valley recognized as a hospital was approved at a meeting attended by representatives from 17 of the 21 school districts in the area, several clergymen and representatives from 17 women's institutes in the district. The centre's board of directors will find out from the department of health in Charlottetown what must be done in order to have the centre obtain full hospital status. The centre has 12 general hospital beds.

Nova Scotia

Plans have been prepared and approved for an entirely new hospital at Middleton. Designed by Douglas A. Webber of Halifax, the hospital will have 67 beds with provision for an increase to 110. Consultants on the project were Agnew, Peckham and Associates, Toronto, Ont.

Grace Maternity Hospital in Halifax — run by the Salvation Army — is to have a new five-storey wing which will house 110 beds. The present 85-bed hospital will be made into a nurses' residence and a separate maternity home for unwed mothers. Prenatal and post-natal clinics, now operated at Dalhousie University, will be moved to the new wing. The cost of the expansion is estimated at $1,250,000.

New Brunswick

There has been an all-out fund-raising campaign in Sackville. The reason is the expansion program under way at the Sackville Memorial Hospital. Eager canvassers hoped to raise $35,000 for their new hospital facilities.

It is expected that construction will begin this summer on a 50-bed hospital for Caraquet, 40 miles east of Bathurst. Plans are by Belanger and Roy, Moncton. The new hospital will be operated by the Hospital Sisters of St. Joseph and will help ease the burden on hospitals in Bathurst and Tracadie.

Quebec

Municipalities west of Montreal, from Lachine to Ste-Anne de Bellevue, are planning a joint survey for the purpose of "spotting" the hospitals required for that area. None now exists and the population is increasing rapidly.

L'Hôpital Jean Talon in Montreal plans a 10-storey building that will increase its capacity from 178 to 450 beds. The new hospital will have many new features — new administrative services, enlarged kitchen, dining room, assembly hall, chapel, new surgical sections and a children's division. The x-ray department will be enlarged and a cancer detection centre set up.

Three men were honoured during a recent ceremony at the Montreal Children's Hospital, Montreal. They were Dr. Mackenzie Forbes, Dr. Harold Cushing, and Lord Atholstan—all deceased. The occasion was the dedication of the new wing (in memory of Lord Atholstan) and the Forbes-Cushing amphitheatre. "With their deeds in mind it was decided to record the names of these men who contributed so much, each in his own sphere, to the founding and to the maintenance in its early days of the Children's Memorial Hospital, forerunner of the Montreal Children's Hospital."

A 400-bed, $10,000,000 mental hospital is well under way in L'Annonciation. The architect is Pierre Rinfret of Quebec City.

A new x-ray machine which enables radiologists to watch bright, moving pictures of the internal organs has been installed in Laval Hospital, Quebec City. The machine includes two electronic units which intensify the brightness of ordinary fluoroscopic x-ray pictures as well as a built-in camera which records the action of internal organs on film.

The new Saguenay General Hospital in Arvida is complete. Construction began in September 1957 and was finished at a cost of $2,000,000. The new hospital, decorated in bright and attractive colours, will provide beds for 62 adults and 22 infants. There are eight private rooms, 19 semi-private rooms and several four-bed wards. Each room has its own bathroom, thermostat, telephone and oxygen outlet.

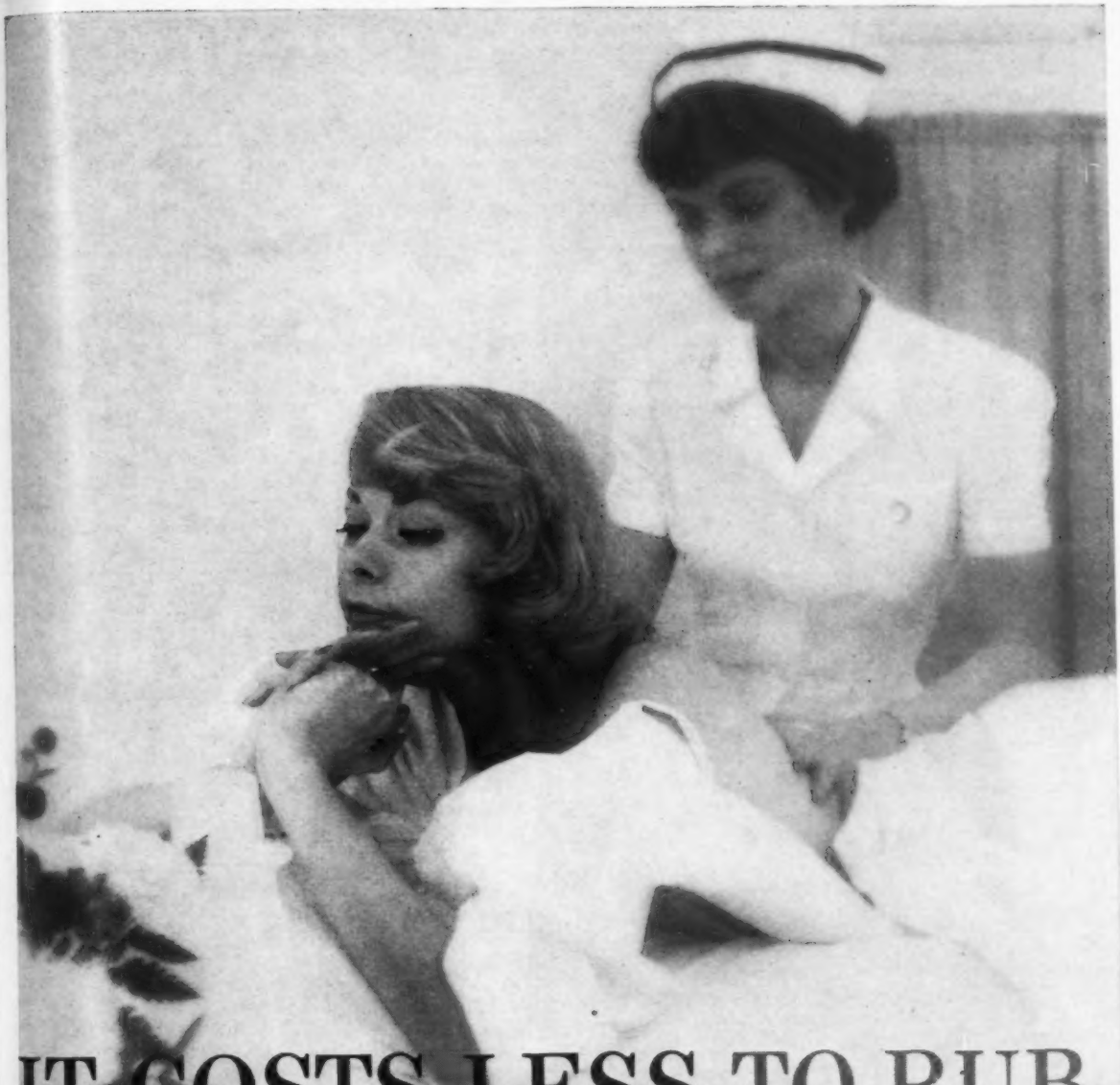
A poison control centre has been set up in the out-patient department of the Sherbrooke Hospital in Sherbrooke. The centre is equipped with stomach pump, suction machine, oxygen, and a cupboard full of antidotes. Duplicate reports will be made on each case treated there. One will be sent to the public health department which will send an official to find out the cause of the accident.

Ontario

The Queensway General Hospital, Toronto, recently saw the opening of its new physical therapy department—the hospital's first expansion since its opening in 1956. Space for the new department was obtained by putting a roof over an open court between the cafeteria and operating rooms. The equipment installed includes an ultra sound generator which can destroy calcium deposits in the body by heat, short wave and micro-wave diathermy machines, and a wax and whirlpool bath.

One of the newest systems of treating the mentally ill is being

(concluded on page 82)



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applied in Cobourg at its day care mental clinic. The centre is administered by staff from the local Ontario Hospital under the Ontario Mental Health Commission. Its nurses all come from the Ontario Hospital across the street. Patients come to the clinic in the hours they find most convenient.

It is expected that tenders will be called next spring for a $1,000,000 extension to the Kenora General Hospital, Kenora. Architects Smith, Carter, Searle and Associates, Winnipeg, Man., worked on the plans for the new wing which will contain a laundry, boiler room, walk-in refrigerator, dining rooms, rest rooms and additional operating theatre space.

Haileybury's Misericordia Hospital has solved its space problems in a very unexpected way. St. Mary's on the Lake Sanatorium is to be made much smaller—the two-storey 98-bed unit will become a one-floor 53-bed institution. This will give the hospital the space necessary for chronic patients. The administrative offices will be moved to the chronic ward and the old offices will be converted to take care of patients. The section of the sanatorium to be used by chronic patients will have a new paint job, new plastering and new flooring. When the entire project is completed, the hospital will have 105 general beds, 53 chronic beds and accommodation for 53 tuberculosis patients.

A vigorous campaign is going on for a hospital in Lennox and Addington County. Planned tentatively is a 75-bed hospital which would cost an estimated $750,000. According to 1957 figures, an average of 75-80 Lennox and Addington County residents are in the Kingston and Belleville hospitals every day.

A reclassification of executive positions at the Hamilton General Hospitals and a shortened work week for the nursing staff have been approved. The nurses will now work a 40-hour week, but this will require no increase in staff.

The new Cottage Hospital in Uxbridge has been officially opened. The ribbon was cut with a gold-plated scalpel. The hospital, which has 29 beds, was completed at a cost of $415,000.

A 300-bed hospital for English speaking Catholics in Ottawa is planned by the Little Company of Mary nursing order. The hospital would cost $2,000,000.

Metropolitan Toronto will build a 632-bed hospital for chronically ill, elderly patients — a cross between a home for the aged and an active treatment general hospital. Construction is to begin in October. The $4,685,000, seven-storey building will be on the site of the present Riverdale Hospital, overlooking Riverdale Park. Three of the five present hospital buildings will be demolished; the other two will be retained. The new semi-circular building, designed by Chapman and Hurst of Toronto, will contain an operating room for minor surgery, x-ray and laboratory facilities and a dispensary centre, as well as a large therapy pool, occupational therapy workshops and balconies on each floor. Two- and four-bed wards are planned.

Manitoba

The Sanatorium Board of Manitoba has put at the disposal of the provincial government 60 beds at Ninette Sanatorium, 40 at Assiniboine Hospital (formerly Brandon Sanatorium) and 36 at Clearwater Lake Hospital, The Pas. The 136 beds have been set aside as "extended treatment" hospital sections for non-tuberculosis, chronically ill patients.

Saskatchewan

Construction and renovations at the Paradise Hill Union Hospital in Paradise Hill are complete. The hospital now has 15 beds. The older building contains a paediatric ward, two double wards, one three-bed ward, laboratory, x-ray room, dark room and admitting office. In the new addition are operating and case rooms, surgeon's scrub room, sterilizing room, nursery, two double wards, one single ward, utility room, and nurses' station.

Tenders were called for an addition and alterations to the south-east wing of the Saskatchewan Hospital in Weyburn. Plans are by architects Izumi, Arnott and Sugiyama of Regina.

Swift Current Union Hospital, Swift Current, has seen the opening of its $229,000, 63-bed extension and its $276,000 nurses' residence.

Alberta

According to Alberta's minister of health, the possibility of a hospital for Stony Plain is good. It is felt that local patients would be happier there than in the already overcrowded Edmonton hospitals. When the time is right, therefore, a provisional hospital board will be set up to draw up tentative plans and decide on the number of beds, architectural design, et cetera.

The government of Alberta plans to have a number of hospitals for the chronically ill constructed in the province. The locations have not been announced, but they will be adjacent to active treatment hospitals. A recent survey by the department of health indicated that 2,500-3,000 beds are needed.

Tenders have been called for demolition of the old General Hospital building in Calgary. The old building is coming down to make way for a new wing. Architects for the project are J. Stevenson and Associates, Calgary. This 175-200 bed convalescent wing will give the Calgary General 915-940 beds and will complete the development of the hospital.

British Columbia

The Fraser Canyon Hospital in Hope was officially opened in January. This new hospital, designed by Anderson and Raymer of Chilliwack, provides accommodation for 26 beds and eight bassinets and has a separate five-bed staff residence. Total construction costs were about $430,000. The hospital is a single storey building with a main floor slab and basement of reinforced concrete and exterior walls of masonry.

Official opening ceremonies took place at Surrey when the new 95-bed Surrey Memorial Hospital was opened in January. This four-storey reinforced concrete building, in a double-corridor design, will provide complete hospital services. The cost was estimated at $1,300,000. Unfinished areas in the hospital will provide accommodation for additional beds in the future, and the eventual capacity, through the construction of two four-storey wings, will be about 313 beds. Architects are Gardiner, Thornton, Gathe and Associates, Vancouver.

The Bella Coola General Hospital, Bella Coola, has signed a contract to construct a 15-bed staff residence. Designed by Birley and Wagg of Victoria, it will be a separate frame building adjacent to the hospital. It is expected that the residence will be completed by August at an estimated cost of $62,000.

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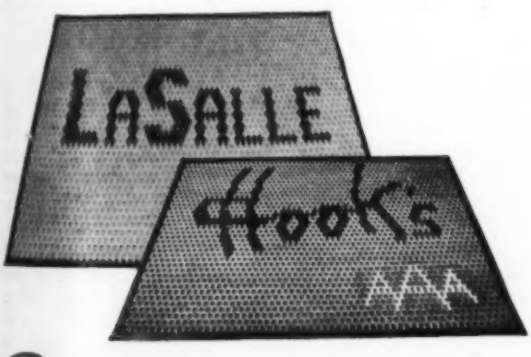

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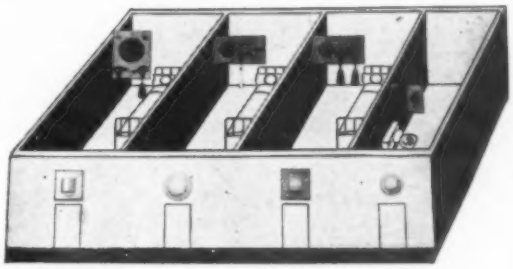

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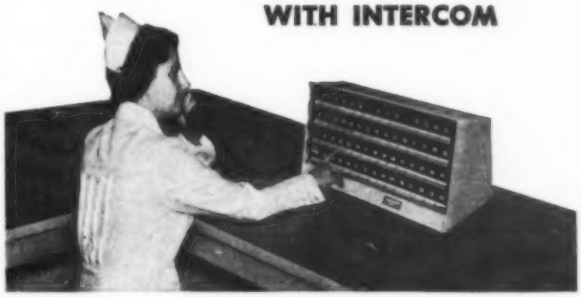

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With the Auxiliaries

Flowers On Wheels

No matter what the season, hospital patients are given a glimpse of spring when a cheery flower cart, blooming with African violets, is pushed through the wards at St. Luke's Hospital, St. Louis, Mo. The flower cart visits patients whose names have been submitted by the occupational therapist, the physical therapist, nurses, or doctors. Patients pick the plants they want, and then volunteers come to see them regularly, checking on the welfare of the plants. They give instructions on plant care, and water the flowers if patients are unable to do so.

If patients are to be in the hospital for a long time, they are encouraged to develop the African violets themselves and watch them change from tiny green leaves to flowering plants.

The project, begun four years ago by the Normandy African Violet Club of St. Louis, is carried on under the sponsorship of the women's hospital auxiliary.—*A.H.A. Hospital Auxiliary Newsletter.*

Sign right here . . .

The ladies of the Port Hope hospital auxiliary have discovered a new and interesting way of making money. They have bought a piece of white linen and have made it into a tablecloth. On it they will embroider the names of grateful patients and persons interested in helping the hospital. Adults will pay one dollar and children fifty cents to see their names embroidered in pale green on the tablecloth. When the cloth is finished it will be used by the auxiliary for hospital birthday parties and the bazaars of the future. The money collected will be used to supply hospital needs.

In Your Easter Bonnet

A spring bonnet tea was held by the auxiliary of the Sudbury General Hospital, but there was no formal parade of models. Instead, the new spring hats adorned the ladies chosen to pour tea and serve refreshments to the guests. Decorations brought still another preview of the warm days to come.

The money raised from the tea (chicken and pork pies, sausage rolls, baked beans and pizza pies were served) and from the bazaar went into the bursary fund for the hospital's Marymount School of Nursing. Each year more students seek financial help so that they may finish their training, and, under this plan, a student may receive $400 during her three-year course. The auxiliary's display of easter bonnets will help a needy student reach her goal.

A Pledge

The new nurses' residence of the McKellar General Hospital in Fort William, Ont., will be completely furnished thanks to a $10,000 pledge made to the hospital by the auxiliary. The lobby, lounge, library and auditorium will be provided with furniture—good news for the nurses who will live in the new building.

Boy with a Dolphin

A lovely marble fountain now stands in front of the Queensway General Hospital, Toronto, Ont. It was a gift from the Kingsway branch of the women's auxiliary. The white marble statue (imported from Italy) is of a boy with a dolphin. Water rises from the dolphin's mouth and cascades over the statue into a pool at the bottom.

The day after the fountain began operating the bottom of the pool was covered with coins. Visitors were already taking advantage of the new fountain and making wishes.

National Convention

When the Canadian Hospital Association holds its biennial meeting the National Council of Hospital Auxiliaries of Canada will be having its meeting too. The time is May 9-13 and the place is the Queen Elizabeth Hotel in Montreal, Quebec.

Delayed Breakfasts

A group of volunteers at the University of Kansas Medical Centre in Kansas City has solved the problem of delayed breakfasts, breakfasts for those patients who had to take some kind of treatment before eating in the morning. This was a job ideally suited to volunteers, for they could give their full attention to the preparation of these trays, something which was not possible before. When they reported for duty, they obtained a list of names and room numbers of patients who would be missing breakfast. Then they waited until the patient was released from the treatment and ready for his meal. Without delay they completed the last minute preparation of the food and then delivered it promptly.

The dietitian who suggested the project reported that the patients were much happier, and the volunteers were proud of a job well done.—*A.H.A. Hospital Auxiliary Newsletter.*

Volunteers are Honoured

Three hundred volunteer workers at the Princess Margaret Hospital, Toronto, Ont., were honoured recently. Each of them was presented with a cadeceus, the emblem of the Canadian Cancer Society in recognition of the hundreds of hours of work contributed to the hospital by each volunteer.

How doth your garden grow?

Here are some words of advice from the handbook of the auxiliary to the Ottawa Civic Hospital, Ottawa. It is called "Plant Your Garden and Grow Good Public Relations".

First, plant five rows of peas—presence, promptness, persistence, purpose, privilege.

Second, three hills of squash—squash gossip, squash indifference, squash unconstructive criticism.

Then, four rows of lettuce—let us be willing, let us be true to our obligations, let us enjoy our work, let us love one another.

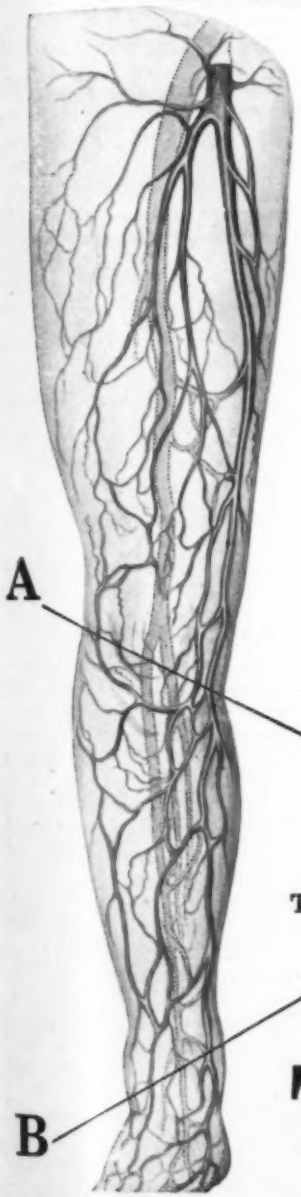
Lastly, four rows of turnips—turn up with a determination to be constructive, turn up with new ideas, turn up with a smile, turn up at each meeting.

Top Man

For the fourth time since it was organized eight years ago, the auxiliary of Grace Cottage Hospital, Townshend, Vt., U.S.A., has elected a man to the top position of auxiliary president. In fact, twenty-five per cent of their members are men. The ladies find that their male colleagues are most active in fund-raising programs. This auxiliary sponsors an annual fair—and for this event the men do most of the work. Are they successful as auxiliary members? Their record speaks for them—for eight years the fair has averaged a net profit of $1,500 in spite of the fact that it is not held in a large city.—*A.H.A. Hospital Auxiliary Newsletter.*

Modern way to combat the fourth largest cause of hospital fatalities

The case for T.E.D. elastic stockings as an improved, low-cost method of leg compression



A to B indicates common origin sites of Thrombo-Embolic Disease.

Pulmonary embolism today ranks fourth in incidence of hospital fatalities (perhaps it would be even higher if the cause of death were not often attributed to the accompanying disease).

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p.85/86ads.

Notes on Federal Grants

Construction

About $80,673 has been awarded to help build the new general hospital in Manitouwadge, Ont. The building will include 33 medical, surgical and obstetrical beds, 11 bassinets and out-patient facilities for the growing mining district.

Prince George and District Hospital, Prince George, B.C., is to have a new hospital of 134 beds, 43 bassinets, with accommodation for 40 nurses and an out-patient department. The federal government has awarded the project $362,120.

The sum of $61,096 has been awarded to Nova Scotia to assist in the construction costs of an addition to Victoria General Hospital, Halifax, N.S. The new addition is to house radiotherapy, a tumor clinic and medical records.

Plummer Memorial Public Hospital, Sault Ste. Marie, Ont., will receive $78,146 for the construction of a nurses' residence and training school. A lecture hall, dietetics and science laboratories, nursing demonstration and classroom, plus offices for the director and instructors, will all be included along with the accommodation for 64 nurses.

The new nurses' residence at the Bethel Hospital, Winkler, Man., will be helped by the federal government with a grant of $23,250. The new building will house 31 nurses.

A grant of $488,286 has been awarded to the new St. Francis Xavier Cabrini Hospital, Montreal, Que. To serve the growing population of the northeast area of Montreal and the new Ville d'Anjou, the new hospital is slated to have 173 beds, 40 bassinets, and accommodation for 11 interns. There will also be an out-patient department, teaching facilities, a pharmacy, clinical laboratory, radiology rooms, emergency, obstetrics, maternity and surgery, as well as a nursery. The hospital will be operated by the Missionary Sisters of the Sacred Heart.

At Hamilton, (Ont.) the Brow Infirmary of the Mountain Sanatorium has been granted $134,666. Plans are afoot for renovating the 35-year old building to make available space for a ten-bed infirmary for the nurses and 95 beds for the chronically ill. Installation of a new elevator, new heating, ventilating, wiring, plumbing and sewage facilities is also desired.

The Whitewood-Moosomin Union Hospital, Whitewood, Sask., gets $20,000 for a new hospital. To be in Whitewood, the hospital will be administered with the Moosomin Union Hospital, a 37-bed unit 30 miles away. Whitewood's new structure is to have 11 beds and six bassinets, an x-ray department and laboratory. The present building, when renovated, will be converted into the nurses' residence and offices for doctors.

A new building — a crippled children's centre—is to be built by Victoria Hospital, London, Ont., with a grant of $131,753. There will be room for 20 more beds and out-patient facilities, along with physical and occupational therapy, and general treatment facilities.

At Tofino, B.C. the General Hospital has been given $6,750 towards the building of a nine-bed nurses' residence.

Assistance of $33,600 goes to the Psychopathic Hospital, Winnipeg, Man., for construction costs of a structure to provide accommodation for 13 patients, out-patient and training facilities under the hospital's renovation and enlargement program.

Kirkland Lake and District Hospital, Kirkland Lake, Ont., receives a grant of $124,726 for a new addition which is to provide 60 beds and a community health centre.

A new nurses' residence for the Hôpital St-François d'Assise, Quebec, Que., will receive $218,956. The new structure will house 211 nurses and include training facilities.

A building to provide medical, surgical and obstetrical services has been planned with 59 beds, 18 bassinets and out-patient services at the Prince Edward County Hospital, Picton, Ont. The project will be helped by a $145,400 grant.

St. Thomas-Elgin General Hospital, St. Thomas, Ont., has been allotted $173,703 to go towards the cost of a two-storey nurses' residence. It is planned to accommodate 125 nurses with facilities for training and an additional four hospital beds.

An addition to the Miramichi Hospital, Newcastle, N.B., will provide 25 beds, 27 bassinets and a community health centre. A grant of $37,300 has been awarded for this new construction. A renovation grant of $24,066 has also been made.

Renovations to the Hotel Dieu St. Joseph, Chatham, N.B., will be helped by a $52,666 grant.

To help defray costs of a new 28-bed wing (including kitchen and laundry) and a community health centre the Centre Grey General Hospital, Markdale, Ont., has been granted $39,566.

A 28-bed addition to Meaford General Hospital, Meaford, Ont., will be helped along by a $56,000 grant.

A new hospital — Hôpital St-Charles de Joliette at Joliette, Que., will bring 1,475 beds for mental patients, and accommodation for 61 nurses into being. The federal government has awarded $2,622,173 to the construction of this provincial hospital.

Diagnosis and Research

The Herzl Health Service Centre, Montreal, Que., has been allotted $20,193 for the purchase of technical supplies and equipment. This Centre supplies preventive services in the field of dentistry and medicine and provides examination and inoculation of children, including chest x-rays, Salk vaccine. There is also a well-being clinic for special services to adults.

The Saguenay County Health Unit, Seven Islands, Que., has been granted $5,030 towards the cost of x-ray equipment for a new anti-tuberculosis clinic to be operated under the direction of the Sanatorium St-Georges de Mont Joli.

To expand radiological facilities the Hotel Dieu de St-Joseph Hospital d'Arthabaska, Que., will receive $43,867 from the federal government.

Two other Quebec hospitals will be helped in the purchase of x-ray and radiological equipment. St. Raymond Hospital, St-Raymond, Portneuf County, Que. will get $11,335; and Notre Dame de Ste-Croix Hospital, Mont Laurier, will receive $29,627.

Hotel Dieu, Quebec City, Que., has been granted $9,651 to go towards the cost of a craniograph,

(continued on page 90)

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Federal Grants

(continued from page 88)

a machine routinely used for x-ray examinations of the skull in cases of cerebral disease.

St. Mary's Hospital, Montreal, Que., has been alloted $40,350 for the purchase of equipment needed to keep pace with this hospital's expanded services. An automatic x-ray processing unit will be included in the additional equipment.

The amount of $5,350 will help purchase equipment for studies in control of gaseous and particulate pollution levels in Vancouver and other municipalities under the direction of the Vancouver Metropolitan Health Committee and the guidance of the B.C. Division of Occupational Health.

The Hotel-Dieu de Quebec, Quebec, will be able to have new x-ray equipment with the help of a $15,829 grant.

Education

Assistance of $7,059 will help to defray the costs of a post-graduate course in obstetrics and paediatrics to be held in Montreal for French-speaking nurses. The course will be under the supervision of the Marguerite d'Youville Institute, Montreal, with practical training to be given at Hôpital Ste Justine and Misericordia Hospital.

The University of Alberta has been granted $12,076 to assist with the cost of a medical laboratory science course of training for staff of hospital laboratories. To consist of two academic years, and appropriate hospital field work, the course will help enable students to write the laboratory technician examinations. The project has been developed to cover bursaries for 17 laboratory technicians who are enrolled in the course this year. Initial expenses for equipment and supplies are also included in the grant.

The federal government has given $50,000 to the province of British Columbia to go towards the cost of technical equipment for laboratories to expand the B.C. Medical Research Institute's facilities. Located in Vancouver the Institute became part of the faculty of medicine, University of British Columbia, at the beginning of this year, and it will move from the site on the grounds of the Vancouver General Hospital into the Medical School Building, where twice as much space will be available. The enlarged centre is to be called the G. F. Strong Laboratory of Medical Research in honour of the founder of the B.C. Medical Research Institute.

Some $24,920 will help finance the renovation of existing teaching facilities and certain patient areas at St. Michael's Hospital, Toronto, Ont. The new facilities will include additional diagnostic rooms, viewing rooms and classrooms.

Coming Conventions

Mar. 16-18—Institute on Labour Relations, sponsored by the C.H.A. and B.C.H.A., Vancouver, B.C.

Apr. 6-9—Nurses-Surgeons Joint Meeting, American College of Surgeons in Canada, Montreal, Que.

Apr. 6-9—A.C.S. Section Meeting on Ophthalmologists, Queen Elizebath Hotel, Montreal, Que.

Apr. 20-23—College of General Practice of Canada, third annual scientific assembly, Toronto, Ont.

May 11-13—Canadian Hospital Association, 15th biennial meeting, Queen Elizabeth Hotel, Montreal, Que.

May 30-June 4—Catholic Hospital Association, 44th annual convention, Saint Louis, Missouri.

June 1-6—International Hospital Federation, 11th international hospital congress, Assembly Rooms, Edinburgh, Scotland.

June 2-5—Canadian Society of Radiological Technicians, 17th annual convention, Queen's University, Kingston, Ont.

June 2-5—Maritime Hospital Association, annual meeting, Algonquin Hotel, St. Andrews, N.B.

June 2-5—Canadian Tuberculosis Association, 59th annual meeting, Nova Scotian Hotel, Halifax, N.S.

June 9-11—Canadian Dietetic Association, 24th annual meeting and convention, Fort Garry Hotel, Winnipeg, Man.

June 9-12—Health Technicians Sixth International Exhibition-Congress, Exhibition Park, Porte de Versailles, Paris.

June 21-25—Canadian Society of Laboratory Technologists, annual meeting and convention, Palliser Hotel, Calgary, Alta.

June 24-26—Comité des Hôpitaux du Québec, annual convention and commercial and scientific exhibition, Montreal Show Mart Inc., Montreal, Que.

July 20-24—Canadian Medical Association—British Medical Association, joint annual meeting, Edinburgh, Scotland.

July 27-31—First International Medical Conference on Mental Retardation, The Eastland Hotel, Portland, Me., U.S.A.

Aug. 2-4—Maritime Conference of the Catholic Hospital Association of Canada, annual meeting, Notre Dame d'Acadie College, Moncton, N.B.

Aug. 24-27—American Hospital Association, annual convention, New York City, N.Y.

Sept. 6-12—World Confederation for Physical Therapy, 3rd international congress, Paris, France.

Sept. 22-23—Catholic Hospital Conference of Alberta, 16th annual meeting, Corona Hotel, Edmonton, Alta.

Oct. 14-16—Saskatchewan Hospital Association, annual meeting and convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 17-18—Catholic Hospital Conference of Saskatchewan, annual meeting, Bessborough Hotel, Saskatoon, Sask.

Oct. 20-23—British Columbia Hospitals' Association, annual convention, Hotel Vancouver, Vancouver, B.C.

Oct. 26-28—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 29-30—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.

Hospital Equipment Exhibition

From May 25 to 30 the international hospital equipment and medical services exhibition will be held at Olympia, London, England. This event, a specialized exhibition with conferences for hospital personnel, hopes to attract visitors the world over. This year conferences have been arranged to include an institute for hospital administrators, an institute for hospital engineers, an institute for public supplies officers, the society of hospital laundry managers, and of the hospital caterers' association. For more complete information write to the organizer: W. R. Kern, M.I.E.D., F.R.S.A., 40 Gerard St., Picadilly, London, W. 1.

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The power output on the vacuum tube cutting current end of the spark gap coagulating current has been substantially increased to give maximum efficiency in cutting and coagulating without excessive destruction of tissue or damage to instruments.

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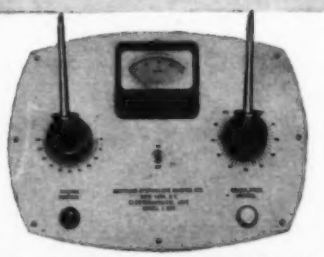
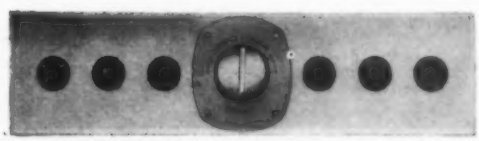


Volt meter on control panel shows output voltage at all times; automatic regulator keeps output constant at 115 volts even when incoming voltage varies between 90 and 135 volts. Handles control power of cutting and coagulating currents and pilot lights indicate which type of current is in use.



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Here and There . . .

Sheffield Children's Hospital New Out-patient Department

The Children's Hospital in Sheffield, England, has a new, two-storey out-patient department. It is linked by corridor with the old buildings and by a new elevator to the upper floors of these buildings. It is so designed that further storeys can be erected to make space in the crowded site of the original hospital.

The department has a pleasant hall and reception area, with a canteen on one side. From here the patient moves to the separate clinics into small waiting areas corresponding to the various departments. In a children's hospital, of course, each patient means two persons, and often as well as a parent, grandma, auntie and a little friend come along too. To lessen noise din, extensive use has been made of acoustic tile on the ceiling, and linoleum tile on the floor. One of the most striking features is the use of primary colours and wallpapers which have proved attractive to the children. Past and present patients have also contributed to the decorations—not, so far, by drawing on the walls—but by making the pictures to be seen in the department, particularly on the corridors and stairways.

Partitioning has been used where possible to anticipate future trends and to enable rooms to be quickly adapted for new purposes. On the first floor there are surgical and orthopaedic clinics, with minor operating theatre and plaster room, and medical, ear, nose and throat clinics, adjacent laboratory, mothercraft and weigh room. Downstairs, in addition to the ophthalmic and orthoptic clinics can be found the pharmacy, almoners' department and medical records department of the hospital, which are now centrally situated near both wards and out-patient department. — *Hospital & Health Management.*

Rehab in the Mediterranean

The first Mediterranean Conference on Rehabilitation will be held in Athens from June 9 to 14, 1959, under the sponsorship of the International Society for the Welfare of Cripples. The planning of national programs for rehabilitation will be the central theme of the conference, which will be organized by the Hellenic Society for Crippled Children in conjunction with a committee of the foremost rehabilitation personalities in Greece. Participants are expected to come from most of the Mediterranean countries, with experts and observers also coming from Great Britain, Poland and the United States—*I.H.F. News Bulletin.*

Special Care Unit

To provide better care for critically ill patients the Maine Medical Centre, Portland, Me., has opened a special care unit. This is a nine-room suite on the sixth floor of the centre's pavilion which will care for twelve patients whose recovery will be speeded by the special equipment and conveniences kept on hand.

This centralized unit is designed to provide more non-M.D. help for the patients, more nurses and nurses' aides. One feature will be that there will be more people to serve the unit than there will be patients. The unit will be fully supplied with special equipment for complex illness, and patients will be within full sight of the nurse on duty.

The largest room in the area is a nine-bed open division, where all patients can be observed by the head nurse. A glass window has been placed in the wall of a two-bed room so that it, too, can be seen from the main nursing station.

The two-bed and a single-bed unit are primarily for isolation cases. Each bed will have permanent bed sides that fold into the frame. Oxygen and suction supplies, held beside the beds and piped from another area of the hospital, eliminate the necessity of bringing the oxygen in tanks. A spotlight is over each bed, to give ample illumination for all bedside medical procedures, and stands have been drilled into the beds to give bases for transfusions and intravenous feeding apparatus. Ceilings are lowered and soundproofed.

The patients will be selected on a basis of need, regardless of whether they are private or free patients on staff services. Besides the greater concentration of facilities and care in the unit, careful policies and regulations will be put into force to ensure the maximum usefulness of the unit to the patients.—*The Bulletin, Maine Medical Centre.*

Psychiatric Hospital in Haiti

The Haiti Psychiatric Institute, the world's first hospital in which treatment of the mentally ill will be based primarily on drug therapy, will begin operation this month at Port-au-Prince. It will have two wards of 10 beds each, an out-patient department, laboratory and administrative facilities; and is financed by three U.S. pharmaceutical companies and the government of Haiti. In addition to grants the drug companies will provide the primary drugs used: the tranquillizers perphenazine and meprobamate, and the psychic energizer iproniazid.

"Our first objective is to improve the care and treatment of mentally ill persons in Haiti," said Dr. Kline, director of research at Rockland State Hospital, Orangeburg, N.Y., who serves as consultant to the Haitian program. "We hope to determine if available drugs and adequate treatment facilities, especially for out-patients, are not a more economical and more socially constructive method of treatment than the traditional method of institutionalizing mental patients. It may be learned, for example, that multi-million dollar mental hospitals are unnecessary." — *A.M.A. News.*

Orthopaedic Research Building Opened in England

A new research building as an extension to the Nuffield Orthopaedic centre near Oxford, England, was opened recently by the Queen Mother. Containing 111 rooms, the new structure is furnished to look "as little like a hospital as possible". Its new facilities include a new department for the Nuffield professor of orthopaedic surgery, a new out-patients' department, a lecture theatre, an x-ray department and accommodation for surgeons.

The building was made possible by a grant of £200,000 from Lord Nuffield. About £170,000 was spent on the extension: the remainder will be devoted to research.—*U.K. Information Service.*

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Book Reviews

TUBERCULOSIS: PREVENTION AND CONTROL by H. W. Hetherington, M.D., M.R.C.P. (London) and Fannie W. Eshleman, R.N., B.S. Published by G. P. Putnam's Sons, New York, 1958. Fourth Edition. Illus. Pp. 404. Price $6.50.

This book is a practical and useful study of tuberculosis—its treatment, prevention and control. The authors, with wide experience in the diagnosis and care of this disease, are well qualified to present the subject.

It has been eight years since the previous edition of this book, and those eight years have been filled with achievement. Here antimicrobial therapy, the importance of the tuberculin test, the practical value of photofluorograms, the modern emphasis on sputum examination by concentrated smear and cultural methods in diagnosis, and the relationship of alcoholism, mental disease and other complicating conditions with tuberculosis are discussed.

However, the new program of tuberculosis control still places a heavy responsibility on the doctors and nurses—both for the care of patients and the protection of the public. This book offers the nurse a thorough knowledge of proper nursing techniques. Now that the trend in public health nursing is toward generalized service with tuberculosis included, every nurse should be informed about these techniques for her own protection as well as for patient's and public's.

FROM WITCHCRAFT TO WORLD HEALTH By S. Leff, M.D., D.P.H., and Vera Leff. Published by the Macmillan Co., New York., 1958. In Canada, by Brett-Macmillan, Toronto, Ont. Pp. 236. Price $4.50.

This is the story of man's struggle against disease. It has been a long struggle and it still goes on. In its course witch-doctors have performed ceremonial dances; Egyptians, Greeks and Romans have sought methods of cure. Pioneers like Galen and Hippocrates were followed by Leeuwenhoek, Leonardo da Vinci, William Harvey, Pasteur. All left a mark on medicine. In the future, more great scientists will arise to take their places beside the Bantings and Salks of our own age. Perhaps they will regard pollution of air just as we regard pollution of water—with horror and disgust.

The last sentence of the book is encouraging: "It has taken man millions of years to progress from the fear of witchcraft to the hope of world health; and from that first glimpse of the future it need take only a generation or two to reach the fulfillment of that hope: a world of healthy, happy people at peace."

OBSTETRIC AND GYNECOLOGIC MILESTONES, by Harold Speert, M.D. Published by the Macmillan Company, New York, 1958. In Canada by Brett-Macmillan, Toronto, Ont. Pp. 700 Illus. Price $15.00.

In this book the author tells the stories behind the eponymic nomenclature of obstetrics and gynecology. Each chapter is an independent essay which includes descriptions of earlier work and biographic sketches. This is background for recent and current clinical practice, and is, in a sense, a record of this specialty's development. It is written by and for a practising obstetrian-gynecologist whose interest lies in specific diseases, instruments and techniques.

THE CENTRAL SUPPLY YEARBOOK, Volume II. Published by *Hospital Topics*, Chicago, Ill. 1958. Illus. Pp. 95. Price $2.00.

Now available, is the second volume put out by *Hospital Topics* of practical articles on up-to-date methods and procedures for central supply room personnel. Ideas for improving C.S.R. efficiency also may be found within these covers. It serves too, as a permanent reference of the material which has appeared in the central supply section of *Hospital Topics* since the publication of Volume I.

CANADA YEAR BOOK 1957-58. Compiled by the Dominion Bureau of Statistics. Published by the Queen's Printer, Ottawa, Ont. Illus. charts, maps. Pp. 1,321. Price $5.00.

This is the book that tells Canada's story. It offers information on almost every measurable phase of the country's development. There are sections on physiography, constitution and government, population, immigration, public health, domestic and foreign trade and so on. A number of maps and diagrams have been included for reference. New features have been introduced this year and extensive revisions made in the material of various chapters. The result is a volume that places the facts about Canada at everyone's fingertips.

FUNDAMENTALS OF INORGANIC, ORGANIC AND BIOLOGICAL CHEMISTRY, by Joseph I. Routh, Ph.D. 4th edition. Published by the W. B. Saunders Company, Philadelphia and London. 1959. Illus. charts. Pp. 384. Price $4.00.

Chemistry in nursing and medicine has, of course, always been important. Dr. Routh's fourth edition is designed to keep pace with the rapidly developing fields of radiochemistry, organic and pharmaceutical chemistry and biological chemistry. Changes suggested to the author by instructors and students have also been included. Reactions and schemes involved in the metabolism of major food stuffs have been given more emphasis, as have the applications of organic compounds to nursing and medicine.

LABORATORY MANUAL OF CHEMISTRY, by Joseph I. Routh, Ph.D. 4th edition. Published by the W. B. Saunders Company, Philadelphia and London. 1959. Illus. Pp. 115. Price $1.75.

This handy, paper-backed manual has been revised because of new material in the textbook mentioned above and in the second edition of *Twentieth Century Chemistry* by the same author. The book begins with a list (followed by diagrams) of the necessary equipment, gives general directions for working in a laboratory and then goes on to lead the student through a series of experiments on such subjects as the metric system, water, cyclic organic compounds and vitamins

HOUSEKEEPING MANUAL OF NORTH SHORE HOSPITAL. Published by *Hospital Topics*, Chicago, Ill. 1958. Price $3.00.

This manual catalogues and summarizes for handy reference the operations of the housekeeping department at this hospital in Manhasset, Long Island, New York. Cleaning standards, housekeeping inventory of physical plant, organization, group work and job descriptions, the work-day schedule, cycle cleaning schedules, and check out schedules are all described.

Shakespeare in the Operating Room

"Oh, pardon me, thou bleeding piece of earth, that I am meek and gentle with these butchers."—*(from Julius Caesar)—in the New Mount Sinai's "Words at Work".*

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Consent Forms

(continued from page 64)

tian Scientists is one of tolerance and respect, and no surgeon would operate on such patient against his consent. At law, every patient has a right at any time to refuse consent to an operation or treatment, and if a patient is known to have strong religious views against such treatment his consent would never be held to be implied by his admission to hospital and he would, as would any other patient, be given full freedom of choice. Hospital staffs may not be in agreement with Christian Scientists, but they should always respect their views.

Blood Transfusions

Jehovah's Witnesses may object to blood transfusions because they believe the Bible prohibits the taking of blood either orally or intravenously and quote Leviticus XI and Acts XV, verse 29, as their authority. Although they say it is largely a matter for the individual to decide according to his own conscience, no one would be penalized in any way if he agreed to the blood transfusion.

During the last war some fanatical Nazis refused to have blood transfusions in case it should be Jewish blood. Similarly, Hindus have been known to refuse blood from Mohammedans and vice versa.

It has been suggested that if a patient will not consent to blood transfusions or operation, one way of relieving the hospital of any liability and at the same time impressing upon the patient the seriousness of his refusal, is to ask him to sign a statement refusing to give consent.

Normally, if the usual consent form has been signed, consent to blood transfusion can be assumed, but if a patient or relative expressly refuses permission for a blood transfusion, then unfortunate though the result may be for the patient, it would be unwise on legal grounds for the hospital to give the blood transfusion.

Chloroform

Religious objection to certain medical treatment is nothing new. Sir James Young Simpson met with bitter opposition when in 1847 he discovered the use of chloroform as an anaesthetic. It was strongly denounced as dangerous to health, morals and religion. Objections were raised to its use during childbirth as directly contrary to religious teaching in Genesis 3: 16 — "In sorrow shalt thou bring forth children". Simpson neatly countered this argument by pointing out that "sorrow" is not synonymous with "pain" and moreover God was merciful enough to anaesthetize Adam by causing him to fall into a deep sleep before removing one of his ribs. Simpson had to battle against prejudice but he ultimately won the victory, and chloroform as an anaesthetic came into universal use.

It is traditional, however, to respect the views of minorities, and present-day religious objections though not understandable to the majority of people, will be respected by all concerned with medical treatment, provided such objectors do not refuse proper treatment for other persons, including children.

Legal Effect of Consent Forms

There is occasionally some misapprehension about the legal effect of consent forms. There are some who think that an operation or treatment performed without a consent form is unlawful, and on the

(concluded on page 100)

Consent Forms

(concluded from page 98)

other hand, that if a patient has signed a form of consent it gives a *carte blanche* to the surgeon, who will not have any trouble afterwards. Neither of these points of view is correct.

Consent in writing to an operation or any special form of treatment is not legally essential, although it is desirable in order to meet the unlikely contingency of the patient subsequently seeking to claim damages on the ground that he did not consent, and therefore the treatment constituted an assault.

There is nothing magical about a consent form! It does not automatically protect a hospital or doctor. It is not a bar to subsequent legal action, as is evidenced in the recent action against Friern Hospital Management Committee when a patient who had signed a consent form claimed damages for injuries sustained during E.C.T.

A form of consent is merely *evidence* that consent has been given for the operation or treatment; evidence which would rebut or help to rebut in law a claim which might be made subsequently by a patient that an operation had been performed without his or her consent, and that it therefore constituted an assault at law and gave rise to a claim for damages. The mere fact that a person has signed a consent form does not prevent him from alleging afterwards that his consent was improperly obtained or that he did not understand what he was consenting to.

Fortunately, claims for assault against surgeons who may have operated without express permission are extremely rare, and even when successful the damages have usually been nominal.

The consent form serves, however, to protect the hospital and doctor to a limited extent. It also safeguards the patient against operations or treatment he may not desire. ■

Hidden Danger

Never use cleaning fluids containing carbon tetrachloride in a room unless windows and doors are open. Never use this chemical after drinking beer — the results could be fatal.

Remember to celebrate

National Hospital Day

May 12 is an important day! It marks the birthday of Florence Nightingale, a woman whose service to mankind will never be forgotten. Now, too, it marks one day in the year when everyone's attention is focussed on the hospitals which carry forth her crusade. You know that your hospital is a comfortable and appropriate setting for the active treatment of illness. The people in your community should be given the chance to view it and learn something of its functions while they are well. Then in time of emergency they will turn to the hospital in confidence.

On May 12, cheered by the warm spring weather, they will welcome your invitation to an open house. So smile your brightest smiles, put out your hands in a friendly greeting, and show yourselves off to the public. Start planning your program for National Hospital Day soon. We've seen the last of winter for a while and now we must look ahead to spring.

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From every point of view—from the patient's, the administration's, the staff's—this new Dixie Matched Food Service will add immensely to the success of modern hospital operation.

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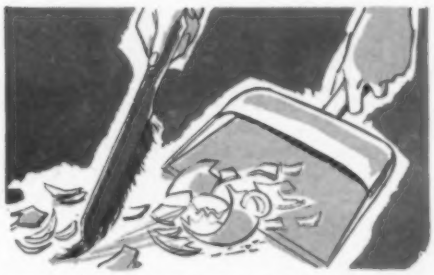

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Flannel in the Mouth

(concluded from page 78)

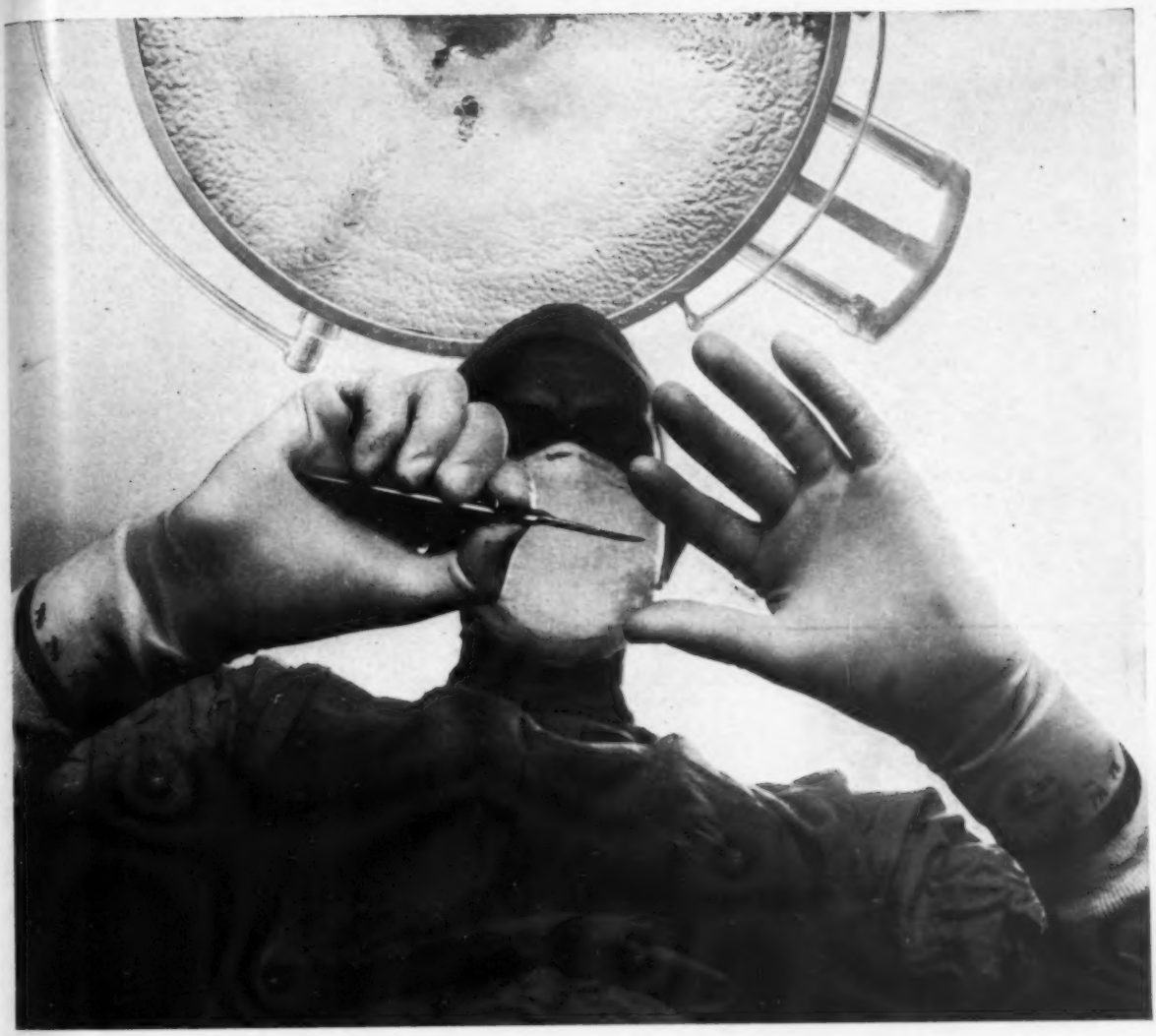
the press, is the use of elegant variation. The sports writer feels he cannot possibly go on repeating a dull, ordinary word like *score;* so he reaches out for jazzy synonyms like *count, tally, notch a point, plunge over the line, rifle one past Sawchuk;* a friend of mine reporting a basketball game went so far as to say "Johnson rustled the mesh for a marker". In the same way, even C.B.C. newscasters won't go on saying "Princess Margaret", when they can think up elegant variations like *the 27-year-old sister of Queen.*

Another method of adding ornament is through moribund metaphors. Metaphor has always been a reliable device for making language vivid: call someone a tiger and you say more about him than a page of adjectives could do. But jargon wears its metaphors with a difference. It is full of *hinges,* where there is no door-jamb; with *pivots,* where Archimedes would have given up in despair; and with strange sporting activities, such as *carrying the ball* without moving from your chair, or *grooming dark horses* far from any stable—though not (with any luck) far from the *grass roots.* The point about these metaphors is that although they might seem to add spice and zip to jargon, they in fact do not; for their original juice has gone, and they are almost as dead as the rest of jargon. But not quite. Used unconsciously by the jargoneer, the moribund metaphor has a habit of giving one last incongruous kick. Thus the executive glares at his staff and says: "There are bottlenecks in this department. But I don't propose to let that stop us. I propose to *harness those bottlenecks".* And his right-hand man jumps up: "I'll support that, Chief,—*to the hilt".* Or Madam Treasurer, reporting on the door-to-door canvass by the ladies' auxiliary, modestly announces: "I think our figures stack up pretty well". ■

Industrial Noise

A study by the American Academy of Ophthalmology and Otolaryngology Research Centre reveals some very interesting discoveries on the relationship between hearing and industrial noise. In addition to permanent hearing losses resulting from extremely loud crashes, there are also temporary shifts in hearing following exposure to loud and continuous din. These temporary shifts carry a warning of permanent hearing loss—if exposure is continued. They can be prevented. Tests show that workers who wear earplugs have normal hearing at the end of the day. Some men object to the plugs on the ground that they may prevent the wearer from hearing warning cries of danger. But, say the experts, the opposite is true.

When the ear is assaulted with noise, its efficiency is cut down so that it hears sounds loud and less loud as equal. Trying to hear speech in a noisy environment, the ear is trying to hear a shout above the storm. The earplug reduces the noise, and lets the ear detect the softer speech patterns, easier to pick up than loud shouts. Hence, earplugs appear to be the major weapon against loss of hearing in industry.—*Rehab. in Canada.*



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Second Annual Congress on Administration

Nearly 1,000 administrators and their assistants from the United States and Canada recently attended the second annual congress on administration held in Chicago. The three-day meeting (from Feb. 5 to 7) was conducted by the American College of Hospital Administrators. Four speakers addressed the group on the behavioural sciences and the College's book award was announced.

A series of 20 management seminars on various subjects pertinent to administration were also held. At the general assemblies Robert N. Wilson, Ph.D., spoke on "The Decision-Making Process in the Hospital"; Chris Argyris, Ph.D. (who won this year's Administrator Award for his book) spoke on "Personality and Organization", J. H. Preiss, Ph.D., spoke on "The Phenomena of Informal Organization", and Oswald Hall, Ph.D., spoke on "Motivation and Morale". Seminar topics covered leadership, motivation, creativity, discipline, human relations, communications, and persuasion.

(continued from page 70)

been expected. Here again the commission will expect good organization and management.

Remember these points:

You should plan in advance. The administrator should perhaps appoint an inventory committee to discuss all details, set the dates, arrange for help and supervise housekeeping.

Issue instructions in writing and review them beforehand with the people who are going to do stock taking.

Housekeeping — before any counting, all areas must be put in good order and stock put in proper position.

The cut-off should be clear-cut. No receiving or issuing should be done during the count. You cannot count properly if supplies are being received and issued.

Your counters should be people who are accurate and conscientious and who know the stock. Common sense should be exercised in deciding how carefully you obtain the quantity in small boxes or bottles, et cetera which are partly used.

You should have people who double check. In a small organization, one person should check another.

Inventory sheets—Proper sheets should be used and stock should be recorded on these systematically up and down so that no stock is omitted.

Obsolete, slow-moving or excess stock should be segregated in a separate area and should be so marked on inventory sheets.

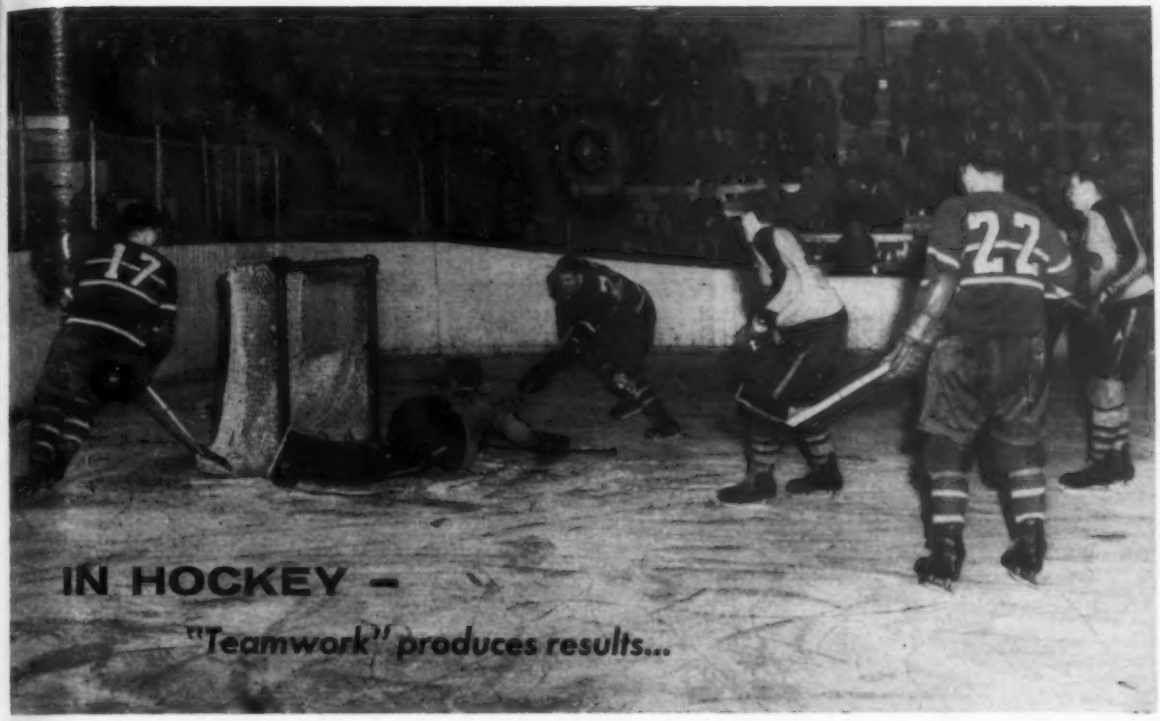
Your auditors should attend during the stock taking to review the procedure you follow and to satisfy themselves on the accuracy and methods. The commission expects that hospital auditors will take more responsibility for hospital accounts in the future than some have accepted in the past.

We expect that the inventory will be valued at the lower of cost or market. This is the usual basis. Market is not significant because the trend in prices today is not lower but higher. No value will be placed on obsolete or unusable stocks which cannot be used for patient care.

Auditing

There must be proper auditing by public accountants of hospital accounts under the insurance plan. The final settlement between the

(continued on page 110)



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You Can Do It

(continued from page 108)

commission and the hospital will be based on actual year-end figures as certified by your auditors. This is a requirement of the hospital insurance plan.

Auditors, therefore, will have a dual responsibility — to the hospitals and to the commission. The regional representatives have discussed this with many of you and auditing is at a high level in many hospitals; but in others the scope is below what are considered to be minimum requirements for public accountants.

One of the best tools for working capital management is a cash budget. This should be made regularly and systematically. You should anticipate all your needs and see what is available for your future requirements. Estimate what your receipts are and what your disbursements are going to be; and these should be revised at least quarterly to try to take into account surprises that lie ahead.

When you come to special projects, such as big repair jobs or capital programs, you should consider another valuable tool. Many organizations forecast these special expenditures quarterly in considerable detail so that the administrator can present to the board a well prepared summary and obtain specific written authorization. There is no doubt that when this information is provided in written form the study on the proposal is more detailed and far-reaching. Then a check list can be used to see that the project is providing the services and operating cost which were promised. This is another means of control in the interests of good management.

This year there will be a greater interest in statistical information. Not only in the data provided on form 106 (admission-discharge claim form) but also in the annual financial and statistical return. This information will be reviewed by the provincial commission and used as a guide more than has been done in the past. The federal Department of National Health and Welfare will also look with more interest on this information. Therefore it should be stressed that in 1959 you have a *more* important duty to see that proper records are set up to accumulate this statistical information.

The monthly and yearly statistics can be valuable information for hospital people as well as for

the commission and federal authorities. They are a guide on operations and on the quality of patient care.

The commission expects that administrators, accountants and other members of the staff will use this financial and statistical information for planning and control. You should be so organized and staffed that you have time to look at it, and discuss it in your supervisory meetings as a basis for future policies and action.

The commission sent out a letter in October 1958, outlining the depreciation allowances on equipment. The commission wishes to be fair to the hospitals and yet not exceed the funds available. Every hospital will have to set up a proper plant ledger—this means a card or sheet for every piece of equipment. In the interest of good control, you will find that a plant ledger is worth the time it takes and that it will also give you an accurate method of obtaining maximum depreciation. Hospitals which use a plant ledger state they provide valuable information for other purposes also.

Points to Remember

In conclusion, I would like to summarize these points:

The accountant's rôle will be just as important in 1959 under the plan as it has been in the past because control remains with the hospital.

Control means that you have an active part in budgeting, and in the teamwork in the hospital which is part of good budgeting.

You will have the same duties as in the past. The commission will expect sound departmentalization of expense, good control on cash, a tough approach on bad debts, the balancing of accounts receivable monthly, and a frank review of the performance of your auditors.

The benefits to you and the hospital of cash forecasting and the setting up of proper appropriations on special projects will be emphasized.

Good records and routines for accumulation of statistical information throughout the year, and the active use of this data, will be stressed.

This is not a complete list, but it certainly indicates the senior position that you, as administrators and accountants, hold in your hospital under the hospital insurance plan. In the future, there will be a stronger challenge than ever to plan carefully and operate wisely. You can do it! ■

The Art of Discovery

In his Recollections and Reflections, the late Sir Joseph John Thomson (1856-1940) British physicist and father of this era of science, had this to say about creative thinking: "There is no better way of getting a good grasp of your subject, or one more likely to start more ideas for research, than teaching it or lecturing about it, especially if your hearers know very little about it, and it is all to the good if they are rather stupid. You have then to keep looking at your subject from different angles until you find one which gives the simplest outline, and this may give you new ideas about it and lead to further investigation. I believe too that new ideas come more freely if the mind does not dwell too long on one subject without interruption but when the trend of one's thoughts is broken from time to time. It is, I think, a general experience that new ideas about a subject generally come when one is not thinking about it at the time, though one must have thought about it a good deal before."—*C.D.A. Journal.*

"Dear Mr. Maugham," wrote a young author, sending some of his short stories to the great writer for criticism, "do you think I should put more fire into my stories?"

"No," wrote back Maugham, "vice versa".—*English Digest.*

Kellogg Foundation

As their 1958 *Annual Report* points out, the W.K. Kellogg Foundation has had a policy of concerning themselves with the application of existing knowledge rather than its creation through research. The Foundation's assistance to the field of health and medicine in Canada as well as other countries is widespread. The Foundation assists in the development of comprehensive programs in graduate and post-graduate medical education, as well as in the strengthening of undergraduate programs in the departments of obstetrics and paediatrics at Dalhousie University in Halifax, N.S. A loan fund for undergraduates at the medical schools of the University of Saskatchewan, University of British Columbia, and the University of Ottawa, has also been set up by the Kellogg Foundation.

In the hospital field financial assistance goes to the improvement of the administration of small hospitals in Manitoba through a co-operative and centralized service of accounting and financial consultation through the Associated Hospitals of Manitoba. Education in hospital administration has been helped at the University of Toronto, the University of Montreal and at the Canadian Hospital Association; and the education program for medical record librarians arranged through the Canadian Hospital Association is also sponsored. A student loan fund for hospital administration graduates at the University of Montreal and the University of Toronto is also aided.

Nursing education is encouraged too. At McMaster University, Hamilton, Ont., there is a program to prepare nurses for the teaching of sciences in schools of nursing. Financial aid is given to selected students enrolled for this training. Other assistance to nursing is given for the University of Saskatchewan's nursing faculty fellowship to a U.S. school to prepare nurses for directing an in-service education program; at the University of New Brunswick where a new school of nursing is being developed along with a program for continuing education for registered nurses. A nursing service administration course at the University of Saskatchewan receives aid from the Foundation also.

Bursaries for Post-Grad Work

The College of General Practice of Canada has accepted the generous offer of Schering Corporation Limited to provide ten bursaries of $500 each during the year 1959. These will go to ten college members to assist them in concentrated two-week post-graduate courses in three hospitals —the Montreal General; l'Hôpital St-Luc, Montreal; and the University Hospital, Saskatoon. The course of study will include daily ward rounds, and attendance at all conferences and surgical procedures, techniques and specialists' clinics in either medical or surgical specialties. The participant may select that which he would like to do during his stay; for example, if he wishes to spend the whole time in cardiology, this will be arranged. One of the staff men will be assigned to supervise the course and to discuss the course with the participant.

100 Years Old

The origin of the Red Cross may be traced directly to Henri Dunant, a Swiss banker. He conceived the idea of a vast international humanitarian organization in 1859.

People forget how fast you did a job—but they remember how well you did it.

—HOWARD W. NEWTON.

They Come and They Go

(continued from page 72)

records, manuals or devices:

1. Job classifications — setting each job in its proper relationship to others.
2. Job titling.
3. Job descriptions. These prove invaluable, particularly in larger hospitals where there is such a diversity of jobs. They are a great help to the person charged with employing personnel, and form the basis for job outlines to acquaint new employees with their duties.
4. Job specifications—these define the preferred qualifications for each job.
5. Complete personnel records.
6. The development and preparation of salary budgets by classified positions.
7. The setting up of training programs and the preparation of job training and procedures manuals.
8. Job orientation.
9. Performance appraisal records which do not limit themselves to a general and vague evaluation of an employee but attempt to appraise the quality of performance of each major duty in a job.
10. The setting up of performance standards where possible, using such devices as work flow process charts and time and motion studies where appropriate.
11. Improved job evaluation and wage administration.

These, then, are the varied uses to which job analysis can be put.

We have cited the reduction of personnel turnover as a prime objective of job analysis, but it is far from being the only one. The resulting general improvement of employee morale, the elimination of most job grievances, the setting of limits of authority and responsibility, the reduction in the number of jobs through improved methods and procedures, will all inevitably lead to a better operated hospital.

Before leaving the subject of job-related problems, we will delve a little more thoroughly into the matter of wage administration in hospitals, particularly in setting wage policy. To do this, it is helpful to recall that in the early history of hospitals, charity was the main characteristic of persons who devoted themselves to the care of the sick. As industrialism grew, making money more and more the accepted means of exchange, the earning of a salary became increasingly necessary for maintaining life. As greater opportunities for gainful employment arose everywhere, hospitals which had negligible financial resources came to be staffed by dedicated persons or by those unfortunates who were compelled to accept meagre hospital salaries because they could not find employment elsewhere. As medical science and technology improved, greater numbers of capable employees were needed in hospitals, and administrators were confronted with the dilemma of paying increasingly high salaries despite restricted budgets. Before the introduction of the hospital services plan, the major impediment to improving hospital salaries was the need to prevent expenditures rising and thereby putting the cost of care out of reach.

Under our hospital services plan, we must consider this eliminated. It is essential that, under a hospital plan financed by the public, the cost of patient care include an amount for salaries and wages similar to that paid to employees in any place of business. We seek the same quality of employees today as is sought by manufacturing, trade and other services. It naturally follows that our salaries must be competitive.

Finally we come to the employee relations program. Here we reach the roots of almost all our personnel problems. A great deal has been said and written on this subject over the past few years so that we now are all reasonably well aware of what is meant by human relations. Therefore, most of us are prepared to accept a broader concept of human relations —one not restricted to the early interpretation of the subject as a policy of non-discrimination in employment and job opportunities, nor to its subsequent acceptance as a technique devised to increase job performance and decrease labour cost—but one that embodies management's recognition that it can succeed only by working *with*, *for* and *through* people. This concept is admirably summed up in a definition of a "supervisor" which we have extracted from an article by W. I. Christopher, the director of hospital personnel services of the Catholic Hospital Association, a definition which can be said to apply to all managerial and executive positions: "A supervisor is one who gets others to do what he wants done, when he wants it done and in accordance with the standard of quality he desires—and in such a manner that both

(continued on page 118)

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They Come and They Go

(continued from page 116)

the worker and the supervisor derive personal satisfaction out of the work, while the work is being performed."

To approach this happy state of affairs, it is necessary for both the hospital and its employees to seek a greater understanding of each other's goals and objectives. The initiative in developing this understanding will, of course, fall on the hospital. Through house organs, newsletters, bulletin boards, personnel manuals, conferences, meetings and well-informed supervisors, the hospital must transmit to its employees the need for their participation in the attainment of the hospital's prime objective — providing good patient care—and of its related goals — educating doctors, nurses, technicians and other personnel to better achieve this purpose.

The hospital must in turn study the needs of its employees with a view to modifying its jobs, policies and personnel techniques, so that they will meet and satisfactorily fill these needs. You have, no doubt, been exposed to many definitions of these needs but we believe they can bear repetition. They include the physical needs for food, shelter, clothes and an acceptable environment, homemaking and family needs; the need for achievement and fair tangible and intangible rewards for this achievement; the need for release from emotional tension; the need for security; the need for recognition of one's human dignity; the need for participation and for being informed; the need for worthy group membership and a sense of belonging, around which one can develop pride and a feeling of loyalty.

The continued and improved development of programs that will satisfy these needs is not only morally right but it is a necessity for efficiency in our hospitals. We must strive to translate these needs into action. If we provide adequate salaries, we shall have satisfied most physical and family needs. If we give friendly encouragement and well-planned promotion programs and merit-plans, we shall have gone a long way towards meeting the need for recognition and rewarding of achievement. If we maintain good employment practices, encourage self-improvement among our employees and make only judicious use of our right to discharge unsatisfactory personnel, we shall have met the need for

security. If we develop good communications with our hospital staff; if we seek employee participation in the development of personnel policies, in conducting job analysis wherever possible, we shall have satisfied the needs of the employees for being informed, for participating, and for identifying themselves with our objectives. These, of course, represent only the highlights of a good employee or human relations program. Its comprehensiveness and the mechanics of its implementation must be worked out under the conditions and circumstances in each hospital.

To sum up, therefore, we feel that the most pressing problems in our hospitals today result from our inability to retain our trained employees, and our failure to impress sufficiently our employees by appreciation of their worth as individuals and as workers. These problems can best be solved by comprehensive job analysis with its related programs, good wage and salary administration, and a practical approach to human relations in our hospitals. ■

Please Stay Seated

A campaign to make the use of seat belts in passenger cars popular will be undertaken by the American Medical Association, the U.S. Public Health Service, and the National Safety Council of the U.S.A., in order to reduce deaths and injuries on the highway. These organizations are inviting other agencies, groups, and business organizations to support the program by promoting installation and use of seat belts in cars of employees and members, and by encouraging their respective publics to use belts.

State officials and appropriate state units will be urged to conduct co-ordinated seat belt campaigns throughout their respective states. No specific brand of seat belt will be tested or approved, but drivers will be urged to install only belts manufactured and installed in accordance with recommendations of the Society of Automotive Engineers.—*A.M.A. News.*

A woman sitting with her small son in a swank restaurant called the waiter over. "Waiter, wrap up these roast beef leftovers for my dog, please," she said.

"Gee, mummy," piped up the little boy. "Are we going to get a dog?"

Housekeeping Institute

A good housekeeper is just as important to a hospital as to a home. Lillian McLeod and Mrs. H. Schilger, two executive housekeepers from Winnipeg hospitals who attended the housekeeping institute held January 26-30 in Regina, Sask., claimed that the average hospital housekeeper must be a combination public relations officer, maintenance man and garbage collector. They were speakers at the institute which was held at the nurses' residence of the Regina General Hospital and sponsored by the Saskatchewan Hospital Association in co-operation with the Canadian Hospital Association. It was a great success.

Program topics included supervision of personnel, work assignment and planning, new employee orientation and training, basic housekeeping procedures, special equipment, sanitation, safety and human relations. Among the speakers scheduled were C. E. Barton, president of the Saskatchewan Hospital Association and executive director of the Regina General Hospital; G. W. Swan, personnel officer of that hospital; Dr. H. O. Dillenberg, medical bacteriologist of the provincial laboratory; Dr. John Nash, chief psychologist of Saskatoon's University Hospital; fire inspectors George Wilson and William J. Wright of Regina, and V. Thomas, chief sanitary officer of Regina rural health. There were practical demonstrations as well as formal addresses, and group sessions encouraged active participation from the delegates.

Nurses to Meet With Surgeons

At the joint nurses-surgeons meeting in Montreal from April 6-9, the American College of Surgeons has arranged a special program for the nurses. Discussions on one person's nursing care, preparation of the nurse for surgical nursing, the management of crisis in human situations, problem and control of staphylococcal infections, specially selected films, and tours and demonstrations at Montreal hospitals, including the Occupational Therapy and Rehabilitation Centre, The Royal Victoria Hospital, Montreal General, Allan Memorial Institute of Psychiatry, Queen Mary Veterans' Hospital, Hotel Dieu, Montreal Children's, Montreal Neurological Institute, Institute of Cardiology, Maisonneuve Hospital, Notre Dame, Ste-Justine, Hôpital Jean Talon, Hôpital de la Misericorde, and Hôpital du Sacré-Coeur. The sessions will all be bilingual.

Presiding officers of the nurses' section are Margaret Wheeler, president of the Association of Nurses of the Province of Quebec; Rae Chittick, director of the School of Graduate Nurses, McGill University; Phyllis Gage, educational director of the Victorian Order of Nurses, Montreal Branch; Alice Girard, director of nursing at Hôpital St-Luc, Suzanne Giroux, the official visitor of nursing schools of province of Quebec and M. Claude Mailhot, director of the Children's Aid Clinic in Montreal.

Conference on Mental Retardation

The first international medical conference on mental retardation will be held this summer from July 27 to 31 in Portland, Maine. The week's program will see many speakers from the United States, England, Germany, Austria and France give papers on topical subjects such as brain anatomy and mental retardation, birth injury, treatment in phenylketonuria, and on the pathology and physiology of mongolism. Facilities for simultaneous translation from and into other languages will be available. Films on scientific subjects concerning mental retardation will be shown and, of course, there will be scientific and commercial exhibits.

THE FRIENDLY, FAMILIAR FACES of "CP" packages help this customer pick the brand that pledges finest quality in every one of its products. Here, a helpful sales clerk passes along a cooking tip in the preparation of Maple Leaf Sausage. Another good reason why his customer looks for the "CP" mark is that she depends on it for purity and freshness.

HOW PACKAGING HELPS TO SET TABLES WITH APPETITE APPEAL

CONVENIENCE in opening and storing any "CP" product is planned by expert package designers. Here, A. J. Tellier and J. S. Brown of the Montreal Plant of Canada Packers, discuss the label for the Domestic Shortening canister with artist-designer Ted Graham.

FRESHNESS AND PURITY of contents is the basic reason for scientific packaging. "CP" standards for this quality are the highest science can set. Here are some of your favourite "CP" packages, specially designed to bring you food at its freshest and purest.

Letter to the Editor

Dear Editor:

I was pleased to see the picture of our hospital on the front cover of the January issue of the Journal. I was also delighted to see that the name "Kitchener-Waterloo Hospital" showed up so well, and thought you might be interested in the history of this sign.

We have a rather expensive sign over our Emergency and Admitting, which is of stainless steel (background lighted), and which can be seen very easily from the street as you approach the hospital. We did not feel at the time when that sign went up that we could afford the money to put the same type of sign, which would have cost about $700 or $800, on the front of the hospital. Then, too, there was some discussion as to whether we would run it vertically on the first column on the left in the picture; or whether we would run it around the band at the front door; or whether we would put it on the far right wall (again in the vertical position). This was all brought to a very final conclusion, since, as the saying goes, "necessity is the mother of invention," by the fact that several years ago the Associated Screen News took some very interesting colour pictures for a film to be shown at the Canadian National Exhibition, Department of Health area. As a result, I was determined that we would have the name on the building they were going to photograph, so, believe it or not, those letters which spell out the name on the front of our building in the picture are nothing more than quarter-inch tempered masonite. They were treated with a lacquer to withstand some of the weather, and then fastened on wooden plugs to the wall to give air space behind. We thought they might last for a year, but they have been there ever since, and they are still in as good a condition as they were when they were put up.

All of this, of course, means that it makes it all the more difficult for me to get somebody to spend $700 on a new sign; so I am afraid the old masonite is going to stay a little longer.

You can understand my interest in the showing of this sign now that you know the background.

Sincerely yours,

Walter Hatch, Administrator, Kitchener-Waterloo Hospital, Kitchener, Ontario.

Twenty Years Ago

From the Canadian Hospital, March, 1939

On the recommendations of a joint committee composed of members of both associations, the Nova Scotia and Prince Edward Island and New Brunswick Hospital Associations plan to hold united sessions at the 1939 annual meetings in June. Joint sessions were advocated for part of the meeting, particularly for that portion dealing with the scientific program. The committee also recommended that joint meetings be held for the alternate years, while in 1940 and other even years, the two associations should meet separately. Final recommendation was that there should be an effort to have the two associations hold the joint meeting in 1941 under some conjoint title, such as "The Maritime Hospital Federation". For all other purposes, however, the associations, for the time at least, would remain distinct.

* * *

We read recently of a patient in a New Zealand hospital who, after keeping an egg in bed with him for 25 days, hatched a leghorn chicken. It has since been proposed that this practice should be encouraged. The idea is that the hospitals will support themselves by the sale of day-old chicks and the patients will forget their troubles in the joys of incubation.

"And how are we this morning?", says the doctor.

"Swell. Lookit", says the patient, lifting the blanket from a clutch of buff orpingtons.

or "You're running a temperature of 102°", says the doctor.

"Fine," says the patient, "it will hasten the blessed event."

* * *

The formal opening of the new $90,000 wing to Mater Misericordia Hospital, Rossland, B.C., took place on February 12. A $15,000 nurses' home was recently opened.

Prize-winning Book

Every year the American College of Hospital Administrators give their "Hospital Administrator's Award" for an "outstanding book on the science of administration". This year it goes to Chris Argyris, an associate professor of industrial administration, School of Engineering, Yale University, for his book *Personality and Organization.*

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement—$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

Director of Nursing Wanted

for approved J.C.A.H. 108-bed hospital planning a 100-bed addition. No School of Nursing at present. Degree in nursing administration preferred but not essential. Successful experience in nursing education would be an advantage. Salary open. Personnel policies include 40-hr. week, pension plan, sick leave, 4 weeks' vacation after one year of service, 8 statutory holidays. Apply: Administrator, North Bay Civic Hospital, North Bay, Ontario.

Hospital Administrator

For Ross Memorial Hospital, Lindsay, soon to provide 140 beds and new Auxiliary Services. Applicants should state qualifications, experience, references, salary expected and when available. Write to Mr. E. Neill Gregory, Chairman, Board of Governors, c/o 20 Colborne St. W., Lindsay, Ontario.

Dietitian Wanted

for modern 65 bed general hospital 20 miles north of Winnipeg, Manitoba. Excellent working conditions, annual leave etc., salary open to negotiation. Apply to F. D. Butler, Administrator, Selkirk General Hospital, Selkirk, Manitoba.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

MARY A. JOHNSON ASSOCIATES

11 West 42 Street, New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

ADMINISTRATOR

Required For 200 Bed General Hospital with nursing school. Written applications only accepted. State qualifications, experience and salary expected.

Address to:

CHAIRMAN OF HOSPITAL COMMISSION

Guelph General Hospital

Guelph, Ontario.

DIETITIAN REQUIRED

for 115 bed hospital centrally located on East Coast of Vancouver Island. 40 hour five day week, four weeks vacation, 10 paid statutory holidays, 1½ days sick leave per month of service cumulative to 60 days. Starting salary $300 to $350 per month, commensurate with experience and qualifications. New 200 bed hospital in final planning stage. Apply giving age, training and experience and references to

Administrator

NANAIMO GENERAL HOSPITAL

Nanaimo, B.C.

WE ARE LOOKING for an ADDITIONAL MEDICAL SOCIAL WORKER

at the

CALGARY GENERAL HOSPITAL

This is a fully modern 850 bed hospital.

Qualifications: B.S.W. or M.S.W. preferably with previous experience in the field.

Salary: $3816-4644 depending upon qualifications and experience (1958 rate.)

Apply to: Personnel Director, Calgary General Hospital, Calgary, Alberta.

Chief Dietitian Required

The Victoria Union Hospital requires the services of—Chief Dietitian to take charge complete new Department now under construction. Apply stating salary and experience to Secretary of Board of Directors, Victoria Union Hospital, Prince Albert, Sask.

UNIVERSITY HOSPITAL

Saskatoon, Saskatchewan

Now has vacancies for Occupational Therapists in Rehabilitation and Psychiatric areas. New 535 bed progressive teaching hospital. Departments offer additional training under medical supervision in all fields.

Salary $264. to $362.50 depending on qualifications and experience.

Benefits include three weeks annual holiday with pay and three weeks sick leave per year.

Applications should be directed to the Personnel Office,

University Hospital, Saskatoon, Sask.

Qualified Dietitians

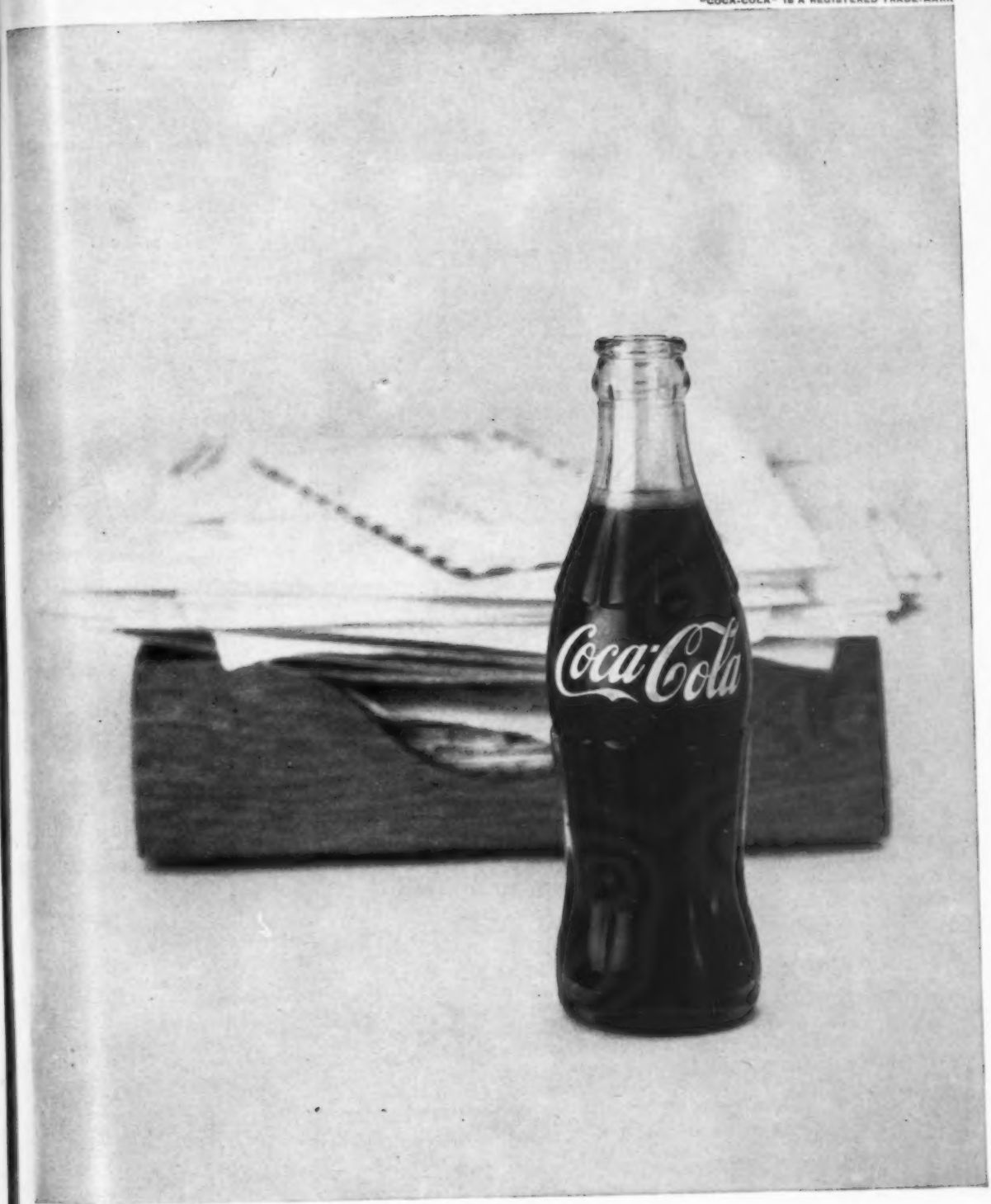
Are needed to complete the staff of six dietitians at the Royal Jubilee Hospital in Victoria, B.C. Excellent personnel policies, 4 weeks' vacation, pension and medical plans, starting salary $280.00. Interesting work in a stimulating environment; new wing planned for future. For details write Miss Mary E. O'Brian, Director of Dietetics.

Drug Facts

The production of any drug is still a major factor in the end price, because of the high expense of research, development and control at manufacture, according to Gordon Gray, president of the Canadian Pharmaceutical Manufacturers' Association. With all the millions which have been poured into research, we, he said, have to date only tapped the possibilities of the so-called wonder drugs. In addition the further development of present drugs will play an even greater rôle in the discoveries now waiting on the doorstep of science. "For this reason, many of our well-known pharmaceuticals will be obsolete by 1975. To ensure that a drug meets the required specifications a manufacturer may carry out as many as 250 separate control tests on a single product. Nor can the cost of this control be reduced, for there cannot be even the slightest margin of error in the final product."

Narcotics Addiction Centre

A new centre for the treatment of drug addiction will soon be opened in Vancouver. Set up by the Narcotic Addiction Foundation of B.C., the centre will be the first in Canada. It will begin on a very small scale, with four beds for in-patients; most of the work will be done with out-patients. Its aim will be rehabilitation as well as psychiatric and medical care.—*C.M.A. Journal.*



Amid the busy bustle of the workaday grind,
there is nothing quite so welcome
as the quick refreshment and lift in ice-cold Coca-Cola.

Doctors' Offices in Hospitals?

The final report of a research project examining the increasing trend toward having physicians set up their private offices in hospitals has been released. Copies of the publication — *Physicians' Private Offices at Hospitals*—may be obtained from the Hospital Council of Philadelphia, (which conducted the research), 311 South Juniper St., Philadelphia, Pa. The price is $2.00. Some interesting, thought-provoking general conclusions were made.

1. A hospital office results in mutual advantage to a doctor and hospital. The physician effectively uses his professional knowledge and skill; the hospital renders greater service through close identification with its medical staff, and greater utilization of its facilities.

2. Tenant-doctors gain a greater understanding of hospital problems, including the non-professional aspects, such as dietary, housekeeping, maintenance and finance. Some administrators believe, however, that proximity to the administrative offices has resulted in unreasonable demands for changes in procedures.

3. Hospital offices for doctors have prompted active interest in group medical practice. They provide savings in professional expenses, and convenience in conference and referral. But they have not been a primary factor in prompting physicians to pool their earnings from the care of private patients.

4. The development of doctors' offices at hospitals is not regarded by doctors or hospitals as a type of social reform. The motivation has been professional, economic and administrative.

5. Doctors' offices at hospitals are a logical development of specialization in medical practice and the reliance upon large capital investment. The doctors provide the professional knowledge and skill. The community provides the funds for buildings and diagnostic and treatment facilities.

6. Hospital offices have not led to improper institutional control over private medical practice. Professional policies and procedures remain the responsibility of the medical staffs of the institutions.

7. Hospital ownership of private office facilities has, in general, been more widely developed than the construction of commercially owned buildings, adjacent to non-profit hospitals. Experience indicates that adequate capital funds can be obtained when a non-profit hospital wishes to provide physicians' private offices.

8. Physicians' private offices will be established at more non-profit community hospitals in the future. Attempts will be made to accommodate all staff members who wish office space, thus avoiding the criticisms that tenant doctors enjoy special privileges.

Thus, this publication covers the whole story and presents clearly a situation that seems both convenient and worthwhile.

Water Softener Savings

Are you getting the full efficiency from your water softening equipment? If a few rules of management, maintenance and operation are heeded, reduced cost and greater efficiency result. Because softeners are simple in operation and needs, they seem to be neglected. This neglect costs time and money in service calls and higher maintenance expense. Here is a simple check list to improve your softeners' efficiency.

1. Use the type and amount of salt recommended by the manufacturer. This varies with make, model and design of softener and is vital to efficient operation.

2. Keep salt storage areas clean, thus avoiding contaminating the zeolite with foreign matter during the salt regeneration. If wet storage is used, the brine tank must be inspected and cleaned if found with sediment. Inspect brine tank every three months.

3. Use a salometer to be sure the brine is at the recommended strength. Brine must be tested as it enters the softener, not at the surface of the brine tank.

4. Post clear, complete, but simple operating instructions on or near the water softener.

5. Have the engineer demonstrate the cycles of the softener operation to other personnel so at least one person per shift is familiar with testing, backwashing, regenerating, rinsing and restoring to service.

6. Be sure the water meter is operating and accurate for control of amounts and rates during backwash, regeneration and rinse cycles.

7. Make certain that the softener operator is observing the manufacturer's recommendations for backwash time and flow rate. This is as vital to softener operation as is the salt regeneration.

8. If between-regeneration backwash is recommended, do not permit the softener operators to neglect the additional backwash.

9. Be sure to test that soap solutions are fresh. Order in small quantities and keep the solution bottles tightly covered at all times.

10. Inspect by-pass valve for leakage regularly. Leaking by-pass valves admit critical amounts of raw water to the softened line.

11. Twice a year check all soft water valves. Oil nuts and bolts on packing glands to avoid leaks and waste of softened water.

12. Keep the softener area clean. Poor housekeeping at the drain pit, sewer or other water disposal facilities can result in costly clogged drains.

13. Once a year inspect the zeolite depth and condition in the softener to be sure they meet manufacturer's specifications for your capacity requirements.

14. Periodically measure the flow rate requirements to be sure softener capacity meets current needs.—*Released from the Salt Institute.*

Tasting Table

"Getting them to try" has been a rewarding experiment for the department of dietetics and nutrition at the University of Kansas Medical Centre. The department's lastest effort to improve employee menus is a "tasting table". The linen-covered, appropriately decorated table made its appearance in the employee cafeteria one lunch hour. Attended by a dietetic supervisor, the table was strategically located so that patrons had to walk by it on their way to the cafeteria line. As they did the dietitian pointed out its attraction, a new and unfamiliar dish, which she urged them to sample. Nurses, physicians and other personnel stopped, tasted the sample, and then recorded their reactions on a card which contained such questions as "Do you like it?", "Does it look good?", and "What would you like to have it served with?".

The table makes its appearance, unannounced, on different days of the week, although not every week. Results of each test are tabulated and the dietitians act accordingly, following the majority rule. If an offering is well-accepted, it appears on the regular menu, helping to add variety to the staff meals. —*Hospital Topics.*

Success is only a matter of luck —ask any man who fails.—*English Digest.*

Instantaneous WRITTEN Communication

The Transceiver

TelAutograph consists of two basic units—the Transceiver and the Receiver. The Transceiver transmits *and* receives. The Receiver only receives. Contact is made immediately by means of a simple selector key, and the system can be used for communication between two or any required combination of instruments.

The Receiver

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with TelAutograph* *Electronic Longhand*

TelAutograph is the modern method of *written* communication that can link admitting offices with records offices, laboratories with wards, wards with operating theatres or residences. It can co-ordinate the activities of any number of departments, anywhere within a 20-mile radius—transmit messages, diagrams, analyses, instantaneously as they are being written—in any language, and complete with personal signatures. In hospitals right across Canada, it is simplifying administration, improving efficiency, and substantially reducing costs.

Automatic Electric can supply you with all the TelAutograph equipment you need—for rental *or* outright purchase. For further information, call or write any Automatic Electric office.

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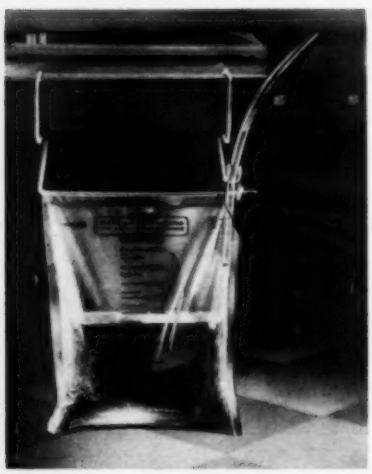
. . . Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

New Drainage Collection Accessory

An ingenious solution to the problem of collecting and disposing of the urine of patients on drainage has been introduced by C. R. Bard, Inc. The unit consists of an inexpensive plastic bag and special hanger that is easily slipped over the side rail of the bed. Tubing from the catheter fits snugly into the bag and is locked into place by the hanger holding the bag.



The Bardic Bedside Bag, being sterile, forms a "closed system" that reduces the problem of ascending infection and odour without the cost of handling and sterilizing glass jugs and special fittings. The transparent bag permits an easy check on colour of contents or sediment, and printed graduations indicate a measured volume.

Because the unit can also be used on a stretcher without protruding or interfering, drainage can be started in the operating or recovery room. This makes transportation easy, with uninterrupted drainage, and reduces the possibility of contamination caused by change-over from plugs or hemostats to a collection system.

Work in central supply is simplified, with no odorous bottles to be cleaned and sterilized. Storage problems are also eliminated. Nursing floors benefit too, according to Bard; because the floor is clear of bottles, housekeeping is made easier and there is no broken glass or spillage from tipped-over bottles to add to the work-load.

The dual hanger is easily attached to the bedside rail, stretcher cart, or wheelchair, and becomes a carrying handle when used by the ambulatory patient. Tubing is securely locked into place, eliminating pins or adhesive tape which can tear the sheets and occasionally injure ironers.

Johnson & Johnson Acquires McNeil Laboratories

Acquisition by Johnson & Johnson of McNeil Laboratories Incorporated, of Philadelphia, Pa., manufacturer of ethical pharmaceutical specialties, has been announced. The McNeil business was established in 1879 by Robert McNeil, the grandfather of the present senior officers, Robert L. McNeil, Jr., and Henry S. McNeil.

The company's principal products are prescription pharmaceuticals in the sedation, skeletal muscle relaxant and antihistamine fields. Wholly-owned subsidiaries operate in Canada and Mexico. The Canadian subsidiary of McNeil Laboratories, Inc., is Van Zant & Company, Limited, 357 College Street, Toronto.

Zimmer Canadian Representative

James F. Hartle, president of Zimmer Manufacturing Company of Warsaw, Indiana, has announced the appointment of Ernest R. Hillrich as company representative for Canada.

Ernest R. Hillrich

Mr. Hillrich, formerly hospital representative for Cyanamid of Canada Ltd., is well known throughout the hospital and medical field. He is to detail doctors and hospitals throughout Canada. Mr. Hillrich will be at 522 Pineland Avenue, Oakville.

To Manage New Winnipeg Office For Johnson & Johnson

L. M. Stevenson

P. W. Remington, vice-president of sales, Johnson & Johnson Limited, has announced the appointment of L. M. Stevenson as manager of Johnson & Johnson's new Winnipeg office.

(continued on page 130)

Across the Desk

(continued from page 128)

Morgue Planning Service Available

The hospital division of Market Forge Company, Everett 49, Mass., have announced the institution of a morgue planning service. Based on many years' experience in working with pathologists, this service is available free of charge to hospital personnel and architects who are planning the lay-out of a new morgue or the remodelling of an existing installation.

Those interested in taking advantage of this service will receive a scale lay-out of the morgue with recommendations for necessary equipment.

New Edwards Sales Office

A new Western Ontario district sales office, located at 542 Main Street East, Hamilton, has just been opened by Edwards of Canada Limited.

Clare J. Reece

The new branch will be under the direction of Clare J. Reece, who was recently appointed Western Ontario district manager. Mr. Reece, a member of the Edwards sales force since 1953, has a wide background in the electrical field. Before joining the company, he served seven years with Canadian General Electric, and three years as a radar technician with the R.C.N.V.R.

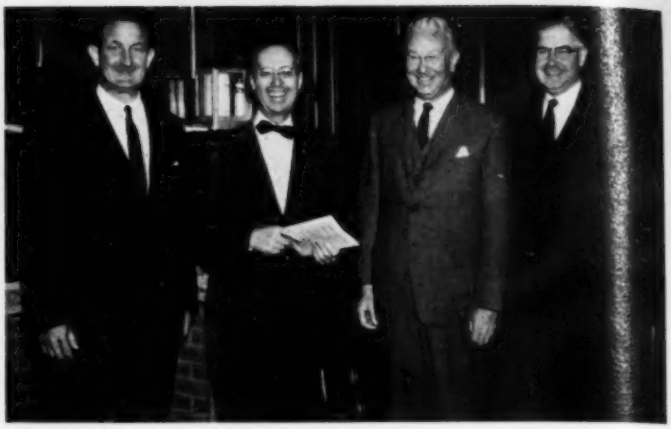
Edward Washbrook, who has been named sales representative, and Betty Blanchard, sales assistant, will complete the staff of the new office.

Walker, Crosweller Appointment

Newly appointed agent for Walker, Crosweller's Rada thermostatic mixing valves in Montreal, Ottawa, and the Province of Quebec, is G. S. Presser, of 814 Rockland Avenue, Montreal 8. He is taking over from Ed Clark, and will work under the company's Markham, Ontario, sales office, headed by George Starr.

Mr. Presser is an engineering graduate of Imperial College, University of London, and has had some years of experience, particularly in the allied field of air conditioning, both in sales and engineering.

Walker, Crosweller & Co. Ltd. expect that the new arrangement will assist their Canadian organization in keeping pace with the increasing market for thermostatic mixing valves and the recently launched, water and fuel-conserving Unatap spray-mixing faucets.



L to R: John H. Castle Jr., F. Ritter Shumway, Wilmot V. Castle, Adrian Comper

Ritter Co. & Wilmot Castle Co. Consolidate

An agreement on a plan to consolidate the Ritter Company and Wilmot Castle Company has been announced by F. Ritter Shumway, president of the Ritter Company, and Wilmot V. Castle, president of Wilmot Castle Company. The two Rochester firms are major producers of professional operating equipment for dentists, physicians, surgeons, and hospitals as well as of production equipment for the pharmaceutical and allied industries.

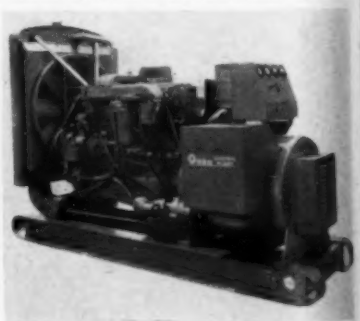
The Castle Company will become a subsidiary of Ritter Company effective upon satisfactory completion of audits, financial and legal details and the acceptance of the plan by all of Castle's common stockholders; and approval, at a forthcoming meeting, of a majority of Ritter stockholders. This should occur in April.

F. Ritter Shumway will assume the duties of chairman of the Castle board and will be the chief executive officer of both companies. Edward J. Ries will continue as chairman of the Ritter Board. Wilmot V. Castle will remain president of Castle and join the Ritter board. John H. Castle, Jr., will stay as vice-president of Castle and become the executive vice-president and a director of Ritter. No basic changes in operating policies of the two companies is contemplated.

High Capacity Diesel Electric Plants Added to Onan Line

Eight new series of diesel-driven electric generating plants, from 50,000 to 200,000 watts, have been announced by D. W. Onan & Sons Inc., Minneapolis, Minnesota.

These new Onan diesel generating sets have been developed especially to meet the demands for auxiliary diesel emergency electric power in modern institutions such as hospitals, where dependable standby electric power insurance is desired and needed.



With this increased capacity, Onan diesel-driven standby plants now have the necessary power to

(continued on page 132)

THE FLOORING THAT SHEDS SCORCH MARKS*

...and won't show scratching; costs little to maintain; lasts a lifetime; is pleasingly resilient; has the largest and most versatile colour range...almost 100 different shades, tints, and pattern variations.

Available by-the-yard or in individual tiles in these 4 types... *all inlaid*...

MARBOLEUM • DOMINION JASPÉ
HANDICRAFT • BATTLESHIP

...in several practical thicknesses

DOMINION LINOLEUM

Dominion Oilcloth & Linoleum Co. Limited, Makers of Dominion Linoleum, Dominion Vinyl Tile and Associated Products.

* Most cigarette and other burn marks can be completely removed by rubbing with steel wool soaked in varsol, then waxing. Dominion Linoleum's resilient composition resists permanent damage from most minor accidents as well as regular scuffing and abrasion. For samples, leaflets on colour range, maintenance and installation, write: Dominion Oilcloth & Linoleum Co. Ltd., 2200 St. Catherine St. E., Montreal.

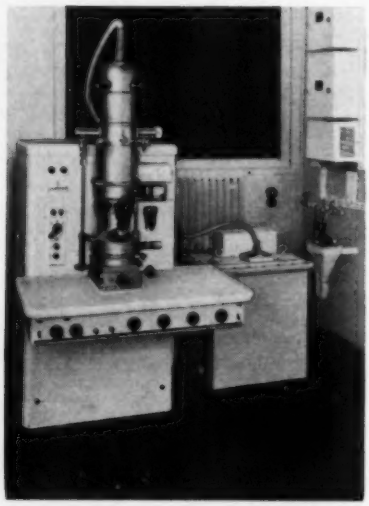
Cafeteria, Montreal Children's Hospital. Floor—Marboleum tiles with decorative inserts.

Across the Desk

(continued from page 130)

operate essential electrical loads such as automatic heating systems, air conditioners, elevators, communications systems, motors and lights for as long as these services are required.

New Medium Power Electron Microscope



A new Siemons Electron Microscope, the Elmiskop II, is now available in Canada. It has been specially designed for routine work, and can be applied where very high resolving power is not required. A development of the Elmiskop I, which is a high performance microscope with a resolving power of up to 7 AU and a direct magnification of from 200 to 160,000 times, the Elmiskop II, has a resolving power of better than 25 AU, and a direct magnification of up to 30,000 times. For complete information, contact the Viditon Corporation Limited, 384 Bank Street, Ottawa, Canada.

New Autoclave Labels

Professional Tape Company, Inc., has announced the availability of Time Autoclave Labels with T.S.I. (time sterile indicator). These labels are unique in that the word "sterile" is invisible at room temperatures. Only when subjected to a complete autoclave sterilization cycle (15 minutes at 250 F.) does the heat-sensitive ink allow "sterile" to appear automatically, providing a *visual* indication of sterility. Accidental activation is impossible, and rigid timing procedures or watchfulness are eliminated. Besides indicating condition of sterilization, standard imprinted Time Autoclave Labels with T.S.I. identify, seal, show size and/or number of articles. A wide selection of stock and custom legend labels are available for every modern hospital and laboratory use.

Write for complete descriptive bulletin TSI-108 to Professional Tape Company Inc., 355 Burlington Avenue, Riverside, Illinois.

Edwards of Canada Limited Appoint Product Specialists

Edwards of Canada Limited has announced the appointment of two specialists in the distributor products and technical products fields.

Frank F. Keating

Frank F. Keating, appointed distributor products specialist, will be in charge of the sales of distributor products, order service, market analysis and statistics, sales promotion and advertising.

Earland M. Dawson

Earland M. Dawson, P. Eng., as technical products specialist, will be in charge of technical products sales and sales engineering—including technical order processing, product design and engineering, and drafting and inspection.

The purpose of the new appointments is to assure adequate planning and control for Edwards' extended 1959 sales program. The specialists will be based at the company's head office at Owen Sound, but both will travel in the field, in liaison and advisory capacities.

Farmer's Wife First With Vitamin C Infant Formula

Cow & Gate (Canada) Limited, manufacturers of Farmer's Wife Infant Formula Milks, have announced that after considerable research it has found a way to incorporate a stable form of vitamin C to its prepared milk formula. Previously it has never been possible to add stable vitamin C to an evaporated milk. The company states that the new process, which is largely dependent on the use of vacuum-packed enamel lined cans, has resulted in an achievement awaited by the medical profession for many years.

The new product will be marketed in two forms; namely, Farmer's Wife Prepared Formula (Red Band) which is made from evaporated whole milk and Farmer's Wife Prepared Formula (Blue Band) which is made from evaporated partly skimmed milk. Both new products contain carbohydrate and vitamin D as well as the new addition of vitamin C, in amounts that supply normal daily requirements for the average infant, and thereby, provide an instant prepared formula.

The company states that doctors will appreciate that in these two new products the carbohydrate is combined with the milk before it is sterilized, thus eliminating any danger of contamination and, at the same time, insuring that the formula is always prepared in the correct proportions.

Apart from the new Red and Blue Band Prepared Formulas, Farmer's Wife will continue to be available in the original three types — Farmer's Wife whole milk, partly skimmed milk, and skimmed milk.

To Introduce New Commercial Cooking Equipment

On April 6, the curtain will be raised on three outstanding new commercial cooking units designed by Bryce Moffat and manufactured by the Commercial Cooking Equipment division of Beatty Brothers. The new equipment will include a new modern design oven which can be used as a matching unit for the

(concluded on next page)

R 400 range, or because of its similarity in styling can be used as a separate oven unit; a revolutionary new fryer and an outstanding new line of 19½ inch depth, space-saver counter equipment, which is an addition to the regular line.

Exhibited for the first time by Magic Chef, which in the future will be sold under the name, Universal Chef, to separate the commercial line from the domestic line sold in the U.S., will be a newly designed, non-heat-conductive gas control dial which will be standard equipment on all Universal Chef gas ovens. Universal Chef products are distributed exclusively in Canada by the Commercial Cooking Equipment division of Beatty Bros.

This new commercial cooking equipment will be on display at the Canadian Restuarant Association Show at the C.N.E. in Toronto, April 6-9.

Personal Call Staff Location System

A unique staff locating and paging system has recently made its appearance on the Canadian market. It is known as the Multitone Personal Call Staff Location System and is manufactured by Multitone Electric Limited of London, England, and distributed in Canada by their subsidiary, Multitone of Canada Limited.

The system consists of a small transmitter control unit usually operated by the telephone switchboard operator. Any number of

receivers working on different wave lengths may be used. The small transistorized receivers clip on pocket or dress of key personnel. When the operator presses a button on the transmitter, a magnetic field is established within a loop of wire surrounding the building. A coded signal is picked up by the selected receiver only. If there is a message to be passed on, the operator can speak directly to the person concerned. All coded calls are completely personal.

The system costs only a few cents a day to operate. It is C.S.A. approved and no Department of Transport license is required as is with a radio system. Complete facts on the Multitone Personal Call system are available from Multitone of Canada Limited, 24 Merton Street, Toronto 7, Ontario.

Midget Steam Generator Bulletin

A new, two-page bulletin, SG-200, describing the Pantex Series "R" model electrode principle steam generator and Steam-Jet cleaner has been announced by the Pantex Manufacturing Company.

Series "R" Speedylectric is described as the first midget-size boiler for high pressure steam up to 250 psig and temperatures up to 405 degrees F.

The new bulletin is available on request from the Pantex Manufacturing Company, 3556 St. Lawrence Blvd., Montreal 18, Que.

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